

# St. Thomas the Apostle

## Physical Form for Athletes (grades 5-8)

Please Print: (Last Name)	(First Name)	(Initial)
Grade _____	Birth Date _____	
Eyes R _____ L _____	Glasses _____	Hearing R _____ L _____
Height _____	Weight _____	Ear, Nose, Throat _____
Lungs _____		Urinalysis _____
Diabetes _____		Pulse _____
Blood Pressure and Heart _____		Heart Murmur _____
Deformities or present illness _____		Prosthesis _____
Hernia evidence _____		Concussion _____
Epilepsy _____		Other _____

Would athletic competition be injurious? \_\_\_\_\_

I hereby certify that, on this date, I examined the above student and recommend him/her as being physically able to participate in all supervised athletics and physical education activities, except as noted:

Date	Signature of Examining Physician
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### Health History

- |   |   |
|---|---|
| <input type="checkbox"/> allergy to bee sting<br><input type="checkbox"/> anemia<br><input type="checkbox"/> arthritis<br><input type="checkbox"/> asthma<br><input type="checkbox"/> concussion<br><input type="checkbox"/> diabetes<br><input type="checkbox"/> eczema<br><input type="checkbox"/> emotional problems<br><input type="checkbox"/> epilepsy<br><input type="checkbox"/> fainting | <input type="checkbox"/> heart murmur<br><input type="checkbox"/> hepatitis<br><input type="checkbox"/> hernia<br><input type="checkbox"/> hives<br><input type="checkbox"/> kidney trouble<br><input type="checkbox"/> migraine headaches<br><input type="checkbox"/> pneumonia<br><input type="checkbox"/> rheumatic fever<br><input type="checkbox"/> other<br><hr/> |
|---|---|

Operations: \_\_\_\_\_  
(Include year)

Fractures: \_\_\_\_\_  
(Include year)

To which drugs is the student allergic? \_\_\_\_\_

If student is now under medical treatment list reason and attending doctor: \_\_\_\_\_