



All Saints Catholic School

PHYSICAL EXAMINATION

(Required for Kindergarten, 4th, & 7th and All Dallas Parochial League participants in grades 5th-8th)

Name _____ DOB _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Vision: R 20 / _____ L 20 / _____ w/Corr _____ Hearing: R _____ L _____

Head/Neck _____ Skin/Scalp _____

Mouth/Teeth _____ Renal/Urinary _____

Heart & Circulation _____ Neurologic _____

Lungs _____ Abdomen _____

Orthopedic _____ Scoliosis Screening-Pass _____ Fail _____

Acanthosis Nigricans Screening-Pass _____ Fail _____

Patient Health History, Findings, and Recommendations: _____

Physical Activity: Restricted or Unrestricted (Please circle)-Explanation- _____

I have examined this student and I have noted any findings that would prevent full participation in the athletic programs at school.

Physician's Printed Name _____ Date _____

PHYSICIAN'S SIGNATURE _____ Phone _____

Rev. 04-08-09