DIOCESE OF TRENTON ELEMENTARY SCHOOL SPORTS PHYSICAL/MEDICAL FORM
ST. VERONICA SCHOOL

Child's Name:____ Date: ____________
Parent's Name: ____ Phone: ___________
Address: ____ Birthdate:_________
Name of Family Physician: ___________________________________ Phone: ___________

DOCTOR'S EXAMINATION (Physician to complete) **DATE OF PHYSICAL:** ___________

Height	__________	Teeth	__________	Thyroid	__________
Weight	__________	Ears	__________	Abdomen	__________
Blood Pressure	__________	Eyes	__________	Hernia	__________
Reflexes	__________	Heart	__________	Lymph nodes	__________
Skin	__________	Lungs	__________	Orthopedic	__________
Posture	__________	Tonsils	__________	Nutrition	__________

Scoliosis (10 yrs. & up) ________________________

Is child on any medication? ___________ If yes, what? _____________________________________

MEDICAL HISTORY (Please include date)

Measles	__________	Pneumonia	__________	Heart Condition	____________
Chicken Pox	__________	Rheumatic Fever	__________	Head Injury	____________
Mumps	__________	Asthma	__________	Diabetes	____________
German Measles	__________	High Fevers	__________	Speech Problem	____________
Scarlet Fever	__________	Convulsive Disorder	________	Lyme	____________

Allergies: ____
Other: ____
Operations: ______________________________ Handicaps: _______________________________
Major Sensory Defects: ______________________ Major Accidents: __________________________
Central Nervous System Infections? (blindness, deafness, meningitis, encephalitis)
____
Other Significant Illnesses: ____

IMMUNIZATIONS DATES

DPT 1.________ 2.________ 3.________ 4.________ 5.________

Polio 1.________ 2.________ 3.________ 4.________

Measles 1.______ 2.______ **or** MMR 1.________ 2.________

Mumps 1.______

Rubella 1.______

Prohibit (HIB) 1.__________ 2.__________ 3.__________ 4.__________

Hepatitis B 1.__________ 2.__________ 3.__________

Varicella 1._________

Tuberculin Test (Mantoux Required) on or after the 4th birthday. Date:_______________ Read:_________________M.M.

NEW VACCINES ____

PHYSICIANS FINDINGS PERTINENT TO PARTICIPATION IN ATHLETIC ACTIVITIES:

Full Participation Allowed __________
Limited Participation Allowed _______
No Participation Allowed ___________
Restriction on Activity _____________
Doctor's Signature
Date: ____
Date of Physical ______________________________________