Saint Anthony Catholic School

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MEDICAL/ATHLETIC CLEARANCE FOR SCHOOL ADMISSION

STUDENT NAME _____ **GRADE ENTERING**_____

DATE OF BIRTH _____**AGE**_____ **SCHOOL YEAR ENTERING** _____

HOME ADDRESS_____

HOME PHONE_____**E-MAIL ADDRESS**_____

FATHER'S NAME_____**CELL PHONE**_____**WORK PHONE**_____

MOTHER'S NAME_____**CELL PHONE**_____**WORK PHONE**_____

PART 1: PHYSICAL EXAMINATION

HEIGHT_____ **WEIGHT**_____ **T**_____ **p**_____ **R**_____

BLOOD PRESSURE_____ **VISION: RT**_____ **LT**_____ **HEARING: RT**_____**LT**_____

CHECK EACH LINE	*Normal*	*Abnormal*	*Not Examined*	*Describe suspicious or abnormal findings*
General Appearance	☐	☐	☐	
Skin: Hair, Nails	☐	☐	☐	
Eyes: External(pupils-cornea)				
Optic fundus	☐	☐	☐	
Muscle balance	☐	☐	☐	
Ears: External				
Auditory acuity	☐	☐	☐	
Tympanic Membrane	☐	☐	☐	
Tympanogram	☐	☐	☐	
Pure Tone	☐	☐	☐	
Nose, Mouth	☐	☐	☐	
Pharynx, Larynx	☐	☐	☐	
Speech	☐	☐	☐	
Teeth, Gums	☐	☐	☐	
Neck, Lymph Nodes	☐	☐	☐	
Thyroid	☐	☐	☐	
Cardiovascular	☐	☐	☐	
Respiratory	☐	☐	☐	
Gastrointestinal	☐	☐	☐	
Genito-Urinary	☐	☐	☐	
Musculo-Skeletal	☐	☐	☐	
Scoliosis Screening	☐	☐	☐	

PART 2: IMMUNIZATION RECORD: PLEASE ATTACH A COPY OF UPDATED IMMUNIZATION RECORD

Please check one: / / *in Good Health* / / *Specific Problem/s Noted* / / *Child with a disability –please specify*_____

This child is physically fit to participate in physical education and/or athletic events and related activities: / / YES / / NO

Name of Physician (PRINT)_____ **Signature**_____ **date**_____
Clinic_____ **Email address**_____
PPD –date given _____**PPD – date read** _____**Results**_____

PARENT/GUARDIAN CONSENT

I hereby give permission for the physician to examine my child so that he/she may obtain medical clearance to participate in athletic activities. Therefore, neither the examining physician nor the school is to be held liable for any abnormalities not detected in this examination. Permission is also granted to my child (NAME)_____**to participate in the athletic activities approved by the Physician as initialed below for SCHOOL YEAR**_____**.**

PARENT/GUARDIAN SIGNATURE_____**DATE** _____

MEDICAL INFORMATION

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

LAST NAME _____**FIRST NAME** _____**MIDDLE NAME**_____

MEDICAL HISTORY: Please check "NO" or "YES" appropriately.

		NO	YES
ALLERGIES: FOOD, MEDICATION, ETC.	IF YES, WHEN?_____	☐	☐
HEART PROBLEMS OR HEART DISEASE	IF, YES, WHEN?_____	☐	☐
CHEST PAINS	IF, YES, WHEN?_____	☐	☐
ASTHMA	IF, YES, WHEN?_____	☐	☐
SHORTNESS OF BREATH	IF, YES, WHEN?_____	☐	☐
HEAD INJURIES	IF, YES, WHEN?_____	☐	☐
FRACTURES	IF, YES, WHEN?_____	☐	☐
WEAK JOINTS OR BACK PROBLEMS		☐	☐
TAKING MEDICATION	IF YES, WHAT KIND?_____	☐	☐
SURGERY	IF YES, WHAT TYPE?_____	☐	☐
BLOOD DISORDER		☐	☐
HERNIA		☐	☐
RHEUMATIC FEVER		☐	☐
DIABETES		☐	☐
HEARING PROBLEMS	IF YES, WHEN?_____	☐	☐
VISION PROBLEMS: GLASSES/CONTACTS NEEDED		☐	☐
CONVULSION/SEIZURES OR BREATHING SPELLS	IF YES, WHEN?_____	☐	☐
OTHER SERIOUS INJURY OR ILLNESS	IF YES, PLEASE EXPLAIN BELOW	☐	☐

REMARKS:

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To the best of my knowledge, the information on this page is accurate and complete.

SIGNATURE OF PARENT OR GUARDIAN _____DATE _____

as of 02/28/25