

Return by AUGUST 1 to SMA

**St. Mary's Academy**  
**2017-2018 MEDICAL FORM & PHYSICAL EXAMINATION**

*\*Physical exam date must be current within the last 365 days. No exceptions will be made for expired exam dates.*

\_\_\_\_\_  
Last Name                                      First                                      Middle                                      Exam Date (good for 365 days)

Date of Birth: \_\_\_\_\_                                      Grade: \_\_\_\_\_

History: Does this child have a history of any of the following? Check if yes.

|                       |                             |                           |
|-----------------------|-----------------------------|---------------------------|
| Allergies: _____      | Diabetes: _____             | Hearing Problem: _____    |
| Asthma: _____         | Ear Infections: _____       | Heart Disease: _____      |
| Bronchitis: _____     | Emotional Problems: _____   | Migraines: _____          |
| Cerebral Palsy: _____ | Epilepsy/Convulsions: _____ | Orthopedic Defects: _____ |

List significant illnesses, accidents, operations, congenital defects, or emotional problems:

\_\_\_\_\_

|                                    |                                   |
|------------------------------------|-----------------------------------|
| Exposure to TB: Yes _____ No _____ | TB Screen Date: _____             |
| Date of Last Tetanus Shot: _____   | Dental Defects: _____             |
| Vision: Right _____ Left _____     | Hearing: Right: _____ Left: _____ |

**\*\*PHYSICIAN SIGNATURE REQUIRED BELOW\*\***

I have reviewed medical history on the date above, and make the following recommendation for participation in athletics.

\_\_\_\_\_ CLEARED WITHOUT RESTRICTION                                      \_\_\_\_\_ CLEARED FOR LIMITED PARTICIPATION

Not cleared for specific sports (please list): \_\_\_\_\_ Reasons:

**I HEREBY CERTIFY THAT I HAVE EXAMINED \_\_\_\_\_ AND THAT THE STUDENT WAS FOUND PHYSICALLY FIT TO ENGAGE IN P.E. or ATHLETICS (except above).**

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
PHYSICIAN NAME (PRINT)

\_\_\_\_\_  
DATE of EXAMINATION

\_\_\_\_\_  
DATE SIGNED