

18300 St. Patrick Road
Biloxi, Mississippi 39532

ST. PATRICK CATHOLIC HIGH SCHOOL



Phone: 228.702.0500
Fax: 228.702.0511

PHYSICAL EXAMINATION FORM

A completed physical form must be completed and on file for the current school year before a student may participate in the athletic program at St. Patrick Catholic High School.

Student Last Name _____ First _____ Middle _____ Date of Birth _____

I state that my signature below authorizes the physicians and athletic staff to conduct this screening. I understand this exam is only for athletic or school activity participation purposes. As such, I agree not to hold the examining physician or any staff member associated with this screening legally liable for any injuries and/or non-indicated medical conditions which may appear.

Parent/Guardian Signature _____ Parent/Guardian Printed Name _____ Date _____

PHYSICIAN EXAMINATION

The information below is to be filled out by the physician. Physicians may use this form or attach a copy of their own, if preferred.

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Orthopaedic Exam

	Norm	Abnl		Norm	Abnl		Norm	Abnl
Spine/Neck	_____	_____	Upper Extremity	_____	_____	Lower Extremity	_____	_____
Cervical	_____	_____	Shoulder	_____	_____	Hip	_____	_____
Thoracic	_____	_____	Elbow	_____	_____	Knee	_____	_____
Lumbar	_____	_____	Wrist	_____	_____	Ankle	_____	_____
			Hand/Fingers	_____	_____	Feet	_____	_____

General Medical Exam

	Norm	Abnl		Norm	Abnl	General Health Comments
ENT	_____	_____	Lungs	_____	_____	_____
Heart	_____	_____	Abdomen	_____	_____	_____
Skin	_____	_____	Hernia (if need)	_____	_____	_____

From this limited screening, I see no reason why this student cannot participate in athletics.

Student needs further evaluation as described above.

Physician Signature _____ Physician Printed Name _____ Date _____