



# PHYSICAL EXAMINATION FORM

### Statement of Confidentiality

The information provided on this form and submitted to Saint Francis Catholic School (SF) is handled confidentially to protect the privacy of the applicant. Only the school's admissions personnel and the administration have access to individual applicant records. The school's planning bodies have access only to aggregate data. Upon enrollment this form will be transferred to the student's cumulative file. Please call SF for our complete student records handling policy.

P.O. Box 22199 Barrigada, Guam 96921 ♦ (671)789-1270/1350 ♦ Fax: (671)789-3900 ♦ Email: [info@sfcsgham.com](mailto:info@sfcsgham.com)

Please type or print in blue or black ink.

### Part One: (To be completed by parent or legal guardian)

This part of the form must be completed by a parent or legal guardian prior to the applicant's physical examination. The information will be reviewed by the licensed health-care practitioner during the examination.

#### Applicant Information:

Last Name, \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
 Male  Female  
 Social Security No. \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

#### Family Physician:

Physician's Full Name \_\_\_\_\_ Physician's Phone No. \_\_\_\_\_ Hospital or Medical Clinic \_\_\_\_\_

#### Health Insurance:

Carrier's Name \_\_\_\_\_ Policy No. \_\_\_\_\_

#### Health History:

Date of applicant's most recent physical examination: \_\_\_\_\_

Does the applicant have a past or present history of:

Condition, Disease or Illness	Yes	No	If "yes", please give necessary details.
Allergies: Food, Medication, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problems or Heart Disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pains?	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions, Seizures or Fainting Spells?	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath?	<input type="checkbox"/>	<input type="checkbox"/>	
Broken Bones?	<input type="checkbox"/>	<input type="checkbox"/>	
Weak Joints or Back Problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Taking Medication?	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Problems: Glasses/Contacts Needed?	<input type="checkbox"/>	<input type="checkbox"/>	
Other Serious Injury or Illness?	<input type="checkbox"/>	<input type="checkbox"/>	

**Immunization:** (Please provide the examining health-care practitioner with a copy of the applicant's immunization record. A copy of the applicant's immunization record must also be submitted to SF.)

#### Signature:

To the best of my knowledge, the information on this page is accurate and complete. I have requested a licensed health-care practitioner to examine the applicant and furnish requested information (that is, "Part Two" on next page) to SF.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Part Two: (To be completed by a licensed health-care practitioner)**

To medical doctor or licensed health-care practitioner:

Please provide physical examination for the prospective student indicated on the front of this form. The medical information in Part One of this form ought to be provided by his/her parent or guardian before the examination. Completion of the information requested below is required for admission to Saint Francis Catholic School. Your assistance is greatly appreciated.

**Examinee's Name:**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**Physical Exam:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

Vision: Right \_\_\_\_\_ Left \_\_\_\_\_ Hearing: Right \_\_\_\_\_ Left \_\_\_\_\_

Check box if normal; circle if abnormal and specify suspicious or abnormal findings in space provided at the right.

<input type="checkbox"/> Eyes: Pupils, Cornea, Optical Fundus, Muscular Balance	
<input type="checkbox"/> Ears: Auditory acuity, Tympanic Membrane	
<input type="checkbox"/> Nose, Sinus, Mouth, Pharynx, Larynx	
<input type="checkbox"/> Skin, Glands, Hair, Nails	
<input type="checkbox"/> Teeth, Gum, Tonsils	
<input type="checkbox"/> Head, Neck, Thyroid, Spine	
<input type="checkbox"/> Speech	
<input type="checkbox"/> Arm, Elbow, Wrist, Hand	
<input type="checkbox"/> Knees, Hips	
<input type="checkbox"/> Ankles, Feet	
<input type="checkbox"/> Growth, Development	
<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Cardiovascular	
<input type="checkbox"/> Abdomen, Hernia	
<input type="checkbox"/> Genito-Urinary	
<input type="checkbox"/> Gastrointestinal	
<input type="checkbox"/> Scoliosis Screening	
<input type="checkbox"/> Muscular Skeletal	
<input type="checkbox"/> Neurological Impressions	
<input type="checkbox"/> Behavior During Examination	
<input type="checkbox"/> Other (specify)	

Please indicate date (mm/dd/yy) of last inoculation: (Note: Applicant is to provide his/her current immunization record.)

DPT/DT/Td: \_\_\_\_\_ IPV/CPV: \_\_\_\_\_ Hib: \_\_\_\_\_ HBV: \_\_\_\_\_ MMR: \_\_\_\_\_ Varicella: \_\_\_\_\_

After reviewing the prospective student's health history and personally examining him/her, what recommendation can you make regarding the individual's participation in physical education class and competitive athletic sports.

Full Participation     Limited Participation     No Participation     Needs Additional Evaluation

If not recommended for full participation, please give reasons & recommendations: \_\_\_\_\_

Any other concerns, comments, or restrictions: \_\_\_\_\_

\_\_\_\_\_  
Examiner's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Hospital or Medical Clinic