ST. FRANCIS SCHOOL
P. O. Box 22199 GMF, Guam 96921
Main Office: (671)789-1270 ♦ Business Office: (671)789-5052 ♦ Fax: (671)789-3900
Email: sfcsadmin@guam.net ♦ Website: sfsguam.com

MEDICAL / ATHLETIC CLEARANCE FORM FOR SCHOOL ADMISSION

Note: *Please submit on or before 1st day of school.*

STUDENT NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____ ETHNICITY _____

GRADE ENTERING _____ SCHOOL YEAR _____

HOME ADDRESS _____

HOME PHONE _____ E-MAIL _____ PHYSICIAN'S NAME _____

FATHER'S NAME _____ CELLPHONE _____ PHYSICIAN'S PHONE NO. _____

MOTHER'S NAME _____ CELLPHONE _____ HOSPITAL/CLINIC _____

BEST NUMBER TO CALL FOR EMERGENCY _____

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:_____ Result:_____

Parental /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: _____

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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 DISEAS 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	☐	☐
CONVULSIONS/SEIZURES OR BREATHING SPELLS IF YES, WHEN? _____	☐	☐
OTHER SERIOUS INJURY OR ILLNESS? IF YES, PLEASE EXPLAIN BELOW	☐	☐

REMARKS:

_____

_____

_____

_____

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

SIGNATURE OF PARENT OR GUARDIAN _____ **DATE** _____