

DIOCESE OF FT. WORTH

(Physical and completed sports packet is required before student can practice and / or play any sport)

CHILD'S NAME: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> First Middle Last </div>	SEX: M F	BIRTHDATE: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> Month Day Year </div>
ADDRESS: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> Street City Zip code </div>		
MOTHER'S NAME: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> First Middle Last </div>	TELEPHONE: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> Home/Cell Work </div>	
FATHER'S NAME: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> First Middle Last </div>	TELEPHONE: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> Home/Cell Work </div>	
IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL: <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> Name Relationship Telephone Number(s) </div>		
1) _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> </div>		
2) _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> </div>		
PLEASE LIST NAME, RELATIONSHIP AND TELEPHONE NUMBER(S) OF THOSE WHO MAY PICK THIS CHILD UP FROM THIS SCHOOL: _____		

a)	Any known chronic illness; Asthma, Cystic Fibrosis, Diabetes, Heart, etc.	Yes: ____ No: ____
b)	Any known allergies; drug, environmental, food; describe:	Yes: ____ No: ____
c)	History of head injury, concussion, seizure, etc? (list last seizure and if student is on preventative medications)	Yes: ____ No: ____
d)	History of any hospitalization or surgery; explain:	Yes: ____ No: ____
e)	Any spinal injuries or spinal defects:	Yes: ____ No: ____
f)	List all medications taken on a daily basis:	
g)	Note special concerns regarding participation in physical education, athletics or sports for your child:	
h)	Does your child wear contact lens (eyes) or have any orthodontic appliance in their mouth?	Yes: ____ No: ____
i)	Any recurrent skin rashes, abscesses in past year? (explain)	Yes ____ No ____

PARENT / GUARDIAN'S SIGNATURE: _____ **Date:** _____

THIS SIDE TO BE COMPLETED BY PHYSICIAN

Student's Name (PLEASE PRINT) _____

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age: yrs. mos.	General Appearance			
Height (no shoes): inches (%)	Skin			
Weight (light clothing): lbs. oz. (%)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck(lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: _____

**IMMUNIZATION RECORDS OR MEDICAL EXEMPTION FROM VACCINES (yearly) MUST BE
SUBMITTED TO SCHOOL: COMPLETED FOR AGE OF STUDENT AND
APPROVED IN ORDER TO COMPLETE ENROLLMENT**

Immunizations Submitted: ☐ Yes ☐ NoImmunizations Approved: ☐ Yes ☐ No

Notes: _____

HEARING SCREEN DATE: _____

	<u>1st screening</u>		<u>Hearing Screening</u>	<u>2nd screening</u>		<u>1st Vision Screening</u>	<u>2nd Vision Screening</u>
at 25 dB	R	L	at 25 dB	R	L	Distance Acuity:	Distance Acuity:
1000 HZ			1000 Hz			R20/____ L-20/____	R-20/____ L-20/____
2000 Hz			2000 Hz			Pass____ Refer____	Pass____ Refer____
4000 Hz			4000 Hz			Fail____	Fail____
						Signature:	Signature:

Spinal Screening: Pass____ Fail____ Refer____ Comments: _____

Patient Health History, Findings and Recommendations: _____

Physical Activity: Restricted or Unrestricted (circle one) Explanation: _____

I have examined the child named on this form, and find that he/she is able to participate in the athletic programs of the school:

Date: _____ Signature: _____
(Stamped signature not accepted)Please print physician's name and address: _____
(MD / DO or PA or RNP working under the direction of a licensed physician)

1/2025