Saint Casimir School

Serving Christ's Students through Faith and Knowledge

Physical Form
School Year 2024-2025

Student Name_____ Date of Birth_____Grade_____

Allergies: ___No known allergies ___food ___medication ___insect __other _____
Type of reaction_____
Medication for reaction_____
Asthma: ___activity induced ___allergy induced ___anxiety induced __other _____
Medication _____ ____as needed ___ prior to exercise
ADD/ADHD: Medication_____Doctor_____
Diabetes: ___Type 1 ___Type 2 Controlled by ___diet only ___diet and oral medication __insulin

Vision: ___Glasses ___Contacts ___No problems **Hearing:** ___wears aids __No problem_____

IMMUNIZATIONS: (Must show Month/Day/Year)

DTaP/DTP/DT	_____	_____	_____	_____	_____
TDaP	_____				
TD	_____				
Polio (IPV)	_____	_____	_____	_____	_____
Measles	_____	_____			
Rubella	_____	_____			
Mumps	_____	_____			
Hepatitis A	_____	_____			
Hepatitis B	_____	_____	_____	3rd Dose at 6 mo. or after 6 mo. of age.	
Hib	_____	_____	_____	_____	
Varicella	_____	_____	< OR> Had chicken pox disease at age _____ Month ____ Year____		
Meningococcal	_____	_____	(Dr.'s signature for verification of chicken pox disease		
			}_____		

(Please check if Normal or Abnormal. If abnormal describe below)

	Normal	Abnormal		Normal	Abnormal
Physical Development	_____	_____	Throat	_____	_____
Nutritional	_____	_____	Lungs	_____	_____
Skin	_____	_____	Heart	_____	_____
Hair and Scalp	_____	_____	Abdomen	_____	_____
Eyes and Vision	_____	_____	Extremities	_____	_____
Ears and Hearing	_____	_____	Orthopedic	_____	_____
Nose	_____	_____	Scoliosis	_____	_____

Describe any abnormal findings or any instructions for student's specific needs _____
_____
_____

PHYSICAL FITNESS EVALUATION: (Please check one of these recommendations)

- ○ I recommend the regular school P.E. program (includes running, basketball, etc.):
- ○ *I recommend modified P.E. activity (includes ping-pong, shuffleboard, throwing, etc.):
  Specify degree and reason_____
- ○ *I recommend exclusion from Physical Education:
  (**REASON MUST BE GIVEN**)_____
  _____

*Recommendation for modified activity or exclusion is effective for the current school year only.
Physician's Signature _____ Date_____
Physician's Name (please print)_____