TRINITY CATHOLIC HIGH SCHOOL
PHYSICAL FORM AND MEDICAL HISTORY

DIRECTIONS: *Please have this form completed by a physician, and return it to the school office by* ***JULY 1st.***

PLEASE NOTE – A separate MSHSAA physical form in addition to this form is required for students wishing to compete in interscholastic athletics.

STUDENT'S NAME_____
(Last) (First) (Middle)

DATE OF BIRTH_____ **PLACE OF BIRTH**_____
(Month) (Day) (Year) (City, State)

PHYSICAL EXAMINATION

HEIGHT_____ WEIGHT_____

Check if *Normal*:

_____Hearing	_____Teeth & Gums	_____Heart
_____Sight	_____Reflexes	_____Lungs
_____Speech	_____Eyes	_____Abdomen
_____Coordination	_____Ears	_____Hernia
_____Posture	_____Nose	_____Extremities & Back
_____Nutrition	_____Throat and Mouth	_____Lymph Glands
_____Skin and Hair	_____Pulse & Blood Pressure	_____Other_____

Should physical activity be restricted? YES_____ NO_____

If "Yes," please specify_____

IMMUNIZATION RECORD

Missouri State Law requires that a student's "Record of Immunization," with completed **DATES of IMMUNIZATIONS**, be on file in the school office at all times.

DPT/DT/TDaP (At least 3 doses, 1 dose received after the fourth birthday and a **TD BOOSTER** with the last ten years)

Date_____ Date_____ Date_____ Date_____ Date_____

Date of **Tdap** _____

ORAL POLIO (At least 3 doses, with 1 dose received after the fourth birthday)

Date _____ Date_____ Date_____ Date_____

MMR (Measles, mumps, rubella) (2 doses) Date_____ Date_____

HEPATITIS B (3 doses) Date_____ Date_____ Date_____

Varicella (Chickenpox) (2 doses) Date _____ Date _____

MCV(MENINGOCOCCAL): (2 doses) Date:_____ Date_____

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-OVER-

MEDICAL HISTORY

Give details concerning:

Accidents: _____

Athletic Injuries: _____

Allergies: _____

Surgeries: _____

Medicines Taken Regularly: _____

Check illnesses or conditions student has experienced:

_____Frequent colds
_____Frequent headaches
_____Nosebleeds
_____Fainting
_____Diabetes
_____Epilepsy
_____Convulsions
_____Ear infections
_____Strep Throat
_____Asthma
_____Tonsillitis
_____Heart disease
_____Menstrual cramps
_____Anorexia Nervosa
_____Chicken Pox
_____Hepatitis
_____Meningitis
_____Bronchitis
_____Pneumonia
_____Rheumatic fever
_____Scarlet fever
_____Tuberculosis
_____Diphtheria
_____Whooping cough
_____Polio
_____Red measles
_____German Measles
_____Mumps

Other pertinent medical history:

_____

_____

_____

Remarks and recommendations concerning this student in the school setting:

_____

_____

SIGNATURE OF PHYSICIAN_____ M.D.

Telephone number of physician_____

Date of Physical: _____