Physical Examination Form

Return to: Mercy High School, Attn: Registrar
2750 Adeline Drive, Burlingame 94010
or fax to 650-343-2316

Full Name				Date of Birth			
Organization							
Height		BP		Vision Left	20/	Hearing Right	
Weight		Pulse		Vision Right	20/	Hearing Left	
Skin		BMI%		Contacts	☐ Yes ☐ No		

☐NL	☐AB	Eyes, Ears, Nose, Throat	☐NL	☐AB	Musculoskeletal	☐NL	☐AB	Shoulder
☐NL	☐AB	Lungs	☐NL	☐AB	Genitalia	☐NL	☐AB	Hip
☐NL	☐AB	Neurological	☐NL	☐AB	Neck	☐NL	☐AB	Knee
☐NL	☐AB	Heart	☐NL	☐AB	Elbow	☐NL	☐AB	Ankle / Foot
☐NL	☐AB	Abdomen	☐NL	☐AB	Wrist / Hand	☐NL	☐AB	Thoracic/Lumber
☐NL	☐AB	Skin	☐NL	☐AB	Back	☐NL	☐AB	General Flexibility
☐NL	☐AB	Cervical						

Describe Abnormals, Recommendations: ____________________

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ALL INCOMING FRESHMAN / TRANSFER STUDENTS MUST COMPLETE BELOW

A Tuberculin Skin Test is required for students new to a school in California. Students who have never attended a school in the state must have written evidence of a Tuberculin Skin Test within 1 year prior to entering High School.

Vaccine	*DATE EACH DOSE WAS GIVEN*			
	First	**Second**	**Third**	**Fourth**
DtaP/DTP/DT/Td				
POLIO (OPV or IPV)				
HEPATITIS B				
MMR				
VARICELLA (Chickenpox)				
Tdap Boost				

Tuberculin Skin Test

Test Needed: ☐ YES ☐ NO

Date: ________ Type: ________

Induration: ___mm

Impression: ☐ Negative ☐ Positive

Chest X-ray required if TB test positive

Date: ________

Impression: ☐ Negative ☐ Positive

- ☐ **Cleared for all sports no restrictions**
- ☐ **Not cleared for any sports**
- ☐ **Not cleared for certain sports**
- ☐ **Not cleared pending further evaluation**

Recommendation: ____________________

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Doctor's Office Officials Stamp

** Not valid without stamp **

Date of physical ____________________ **(Not accepted without)**

Name of physician ____________________

Address ____________________

Phone ____________________

Signature of physician ____________________

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