CATHEDRAL CATHOLIC
HIGH SCHOOL
Home of the Dons

ATHLETIC PHYSICAL FORM (2020-2021)

NAME:		GRADE:	AGE:

DATE OF EXAM:		***Exam MUST be completed** on or after Friday, June 5, 2020*

***Please note: Physical exam must be performed and signed by a Physician (MD/DO), Physician's Assistant (PA), or Nurse Practitioner (NP) licensed in the State of California.**

DATE OF BIRTH:		SEX: ☐ MALE / ☐ FEMALE
HEIGHT:	WEIGHT:	BMI:
SPORTS:		

VITAL SIGNS		
BLOOD PRESSURE:	PULSE:	RESPIRATIONS:

VISION		
RIGHT EYE:	LEFT EYE:	PERL:
TESTED WITH CORRECTIVE LENSES: ☐ YES ☐ NO	☐ GLASSES ☐ CONTACTS	

PHYSICAL EXAM			
	NORMAL	ABNORMAL	COMMENTS
APPEARANCE/SKIN			
EYES/EARS/NOSE/THROAT			
HEAD/NECK/LYMPHATICS			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL/URINARY			
MUSCULOSKELETAL			
NEUROLOGICAL			

PHYSICIAN CLEARANCE (*MUST check one*)		
	CLEARED FOR UNLIMITED PARTICIPATION / NO RESTRICTIONS	
	LIMITED PARTICIPATION	*EXPLAIN*:
	WITHHELD FROM PARTICIPATION	*EXPLAIN*:

I have reviewed the medical history and given a thorough physical examination to the above-named student. I certify that all the important medical information has been included, and the information is complete and accurate.

*PHYSICIAN'S SIGNATURE: ______________________ DATE: __________

(*Must be licensed in the State of California)

PHYSICIAN'S NAME (printed): ______________________ PHONE NUMBER: __________

PHYSICIAN'S STAMP OR BUSINESS CARD ***(Required)***:

5555 Del Mar Heights Road, San Diego, CA. 92130
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