June 2026

SIFA LACS STUDENT MEDICAL EXAMINATION FORM

Student's Full Name: **Date:**

Phone: Race:

Address: Date of Birth: Age:

Place of Birth: Sex:

Father's Name: Mother's Name:

A. ~ HISTORY OF IMMUNIZATIONS, DISEASES, OPERATIONS, INJURIES ~

IMMUNIZATION OR DISEASE	DATE OF ILLNESS	DATE OF IMMUNIZATION	LAST BOOSTER
DIPHTHERIA			
PERTUSSIS (whooping cough)			
TETANIUS			
POLIO - ORAL			
POLIO - SALK			
MEASLES (Rubeola)			
SMALLPOX			
MUMPS			
GERMAN MEASLES (Rubella)			
OTHER ( )			

	DATE	COMMENTS
CHICKENPOX		
SCARLET FEVER		
RHEUMATIC FEVER		
DIABETES		
ANEMIA (sickle cell)		
PARASITES (worms-type?)		
ALLERGY (type?)		
SEIZURES		
INJURY, FRACTURE		
OPERATION		
OTHER/ALLERGIES (specify)		

TUBERCULIN TEST (type) DATE: NEGATIVE: ☐ POSITIVE: ☐ X-RAY?

B. PHYSICAL EXAMINATION HEIGHT: WEIGHT: BLOOD PRESSURE:

CHECK (✓) ONLY	IF ABNORMAL OR	NEEDS FOLLOW UP	PHYSICIAN'S COMMENTS, FINDINGS, TESTS (use back side if needed)
NUTRITION			
NEUROLOGIC			
ORTHOPEDIC (incl. arches)			
SKIN, SCALP			
EYES	R L		
VISUAL ACUITY	R L		HAS GLASSES? CONTACT LENSES?
COLOR VISION			
EARS	R L		
AUDITORY ACUITY	R L		HAS HEARING AID?
SPEECH			
NOSE, THROAT			
MOUTH, TEETH			
GLANDS, THYROID			
HEART, LUNGS			
ABDOMEN			
GENITALIA			

C. LABORATORY (if needed) HEMOGLOBIN: GM., HEMATOCRIT: %, URINE: FECES:

D. PHYSICIAN CHECK (✓) BOX:	NO	YES	PHYSICIAN'S COMMENTS (use back side if needed)
EMOTIONAL/MENTAL/BEHAVIOR PROBLEM			
HEALTH HABITS PROBLEM			
PHYSICAL DISABILITY - LIMITS ACTIVITY			
RESTRICTION NEEDED			
ENCOURAGE PARTICIPATION			
OTHER DISABILITY			
SEIZURES			
ON MEDICATION ( )			
FOLLOW-UP RECOMMENDED			
FOLLOW-UP COMPLETED			

This student has completed the immunizations required by the Government: ☐ YES ☐ NO and in my opinion is free of any communicable disease and may be admitted to school ☐ YES ☐ NO

Student's usual Physician: Examining Physician:

Telephone#: Telephone#: License#:

☐ **YES** This Student **MAY** participate in **Physical Education** and **Athletic Sports Activities**.

☐ **NO** This Student **MAY NOT** participate in **Physical Education** and **Athletic Sports Activities**.

If NO, please specify:

This form will be used as a School Physical, P.E. Physical, and Sports Physical

Examining Physician: **Telephone#:** **License#:**