Name ______________________ Grade __________ Birthday ___/___/___

Date of Exam ___/___/___

Height ______________

Weight ______________

Vision R ________ L ________

With Glasses R ________ L ________

Blood Pressure ______________

Pulse Rate ______________

__(X)__ Examined and Normal
______ Skin
______ Heart
______ Lungs
______ Abdomen
______ Hernia
______ Bones & Joints
______ Urine Protein & Sugar

Date of last Tetanus Shot ___/___/___

Restricted Sports ______________________
(If none, write NONE)
Physician Signature ______________________
I hereby give permission for my child to represent St. Frances Cabrini in approved sports except where restrictions are indicated.

Date ____________ Parent Signature ______________________