



Saint Casimir School

Serving Christ's Students through Faith and Knowledge

Physical Form School Year 2025-2026

Student Name _____ Date of Birth _____ Grade _____

Allergies: ☐ No known allergies ☐ food ☐ medication ☐ insect ☐ other _____

Type of reaction _____

Medication for reaction _____

Asthma: ☐ activity induced ☐ allergy induced ☐ anxiety induced ☐ other _____

Medication _____ as needed ☐ prior to exercise

ADD/ADHD: Medication _____ Doctor _____

Diabetes: ☐ Type 1 ☐ Type 2 Controlled by ☐ diet only ☐ diet and oral medication ☐ insulin

Vision: ☐ Glasses ☐ Contacts ☐ No problems **Hearing:** ☐ wears aids ☐ No problem _____

IMMUNIZATIONS: (Must show Month/Day/Year)

DTaP/DTP/DT _____

TDaP _____

TD _____

Polio (IPV) _____

Measles _____

Rubella _____

Mumps _____

Hepatitis A _____

Hepatitis B _____

Hib _____

Varicella _____

Meningococcal _____

_____ 3rd Dose at 6 mo. or after 6 mo. of age.

< OR > Had chicken pox disease at age _____ Month _____ Year _____

(Dr.'s signature for verification of chicken pox disease

_____ }

(Please check if Normal or Abnormal. If abnormal describe below)

	Normal	Abnormal		Normal	Abnormal
Physical Development	_____	_____	Throat	_____	_____
Nutritional	_____	_____	Lungs	_____	_____
Skin	_____	_____	Heart	_____	_____
Hair and Scalp	_____	_____	Abdomen	_____	_____
Eyes and Vision	_____	_____	Extremities	_____	_____
Ears and Hearing	_____	_____	Orthopedic	_____	_____
Nose	_____	_____	Scoliosis	_____	_____

Describe any abnormal findings or any instructions for student's specific needs _____

PHYSICAL FITNESS EVALUATION: (Please check one of these recommendations)

- ☐ I recommend the regular school P.E. program (includes running, basketball, etc.):
- ☐ *I recommend modified P.E. activity (includes ping-pong, shuffleboard, throwing, etc.):

Specify degree and reason _____

- ☐ *I recommend exclusion from Physical Education:

(REASON MUST BE GIVEN) _____

*Recommendation for modified activity or exclusion is effective for the current school year only.

Physician's Signature _____ Date _____

Physician's Name (please print) _____