



**Academy of Our Lady
of Peace Physical
Form 2026-2027**

Name: _____
Exp. Date: _____

All freshmen and transfer students **MUST** have a current physical (dated June 1, 2026 or LATER) on file no later than the **FIRST** day of school. If the student does not have a completed physical form on file they **WILL NOT BE ALLOWED** to participate in Physical Education class. Non---participation in Physical Education class may affect their grade.

****TO BE ELIGIBLE FOR ATHLETICS PARTICIPATION: THIS PHYSICAL MUST BE PERFORMED June 1, 2026 OR LATER AND UPLOADED TO DOCUMENT-LOK IN YOUR POWERSCHOOL ACCOUNT NO LATER THAN JULY 25, 2026****

NAME:		SPORT (S):	
BIRTH DATE:		AGE:	GRADUATION YEAR:
HEIGHT:		WEIGHT:	
BLOOD PRESSURE:		PULSE:	RESPIRATIONS:
VISION R	VISION L	PERL: <input type="checkbox"/> YES <input type="checkbox"/> NO	CORRECTIVE LENSES: <input type="checkbox"/> YES <input type="checkbox"/> NO

	NORMAL _____	ABNORMAL _____	COMMENTS:
APPEARANCE/SKIN	NORMAL _____	ABNORMAL _____	_____
EYES/EARS/NOSE/THROAT	NORMAL _____	ABNORMAL _____	_____
HEAD/NECK/LYMPHATICS	NORMAL _____	ABNORMAL _____	_____
CARDIOVASCULAR	NORMAL _____	ABNORMAL _____	_____
RESPIRATORY	NORMAL _____	ABNORMAL _____	_____
GASTROINTESTINAL	NORMAL _____	ABNORMAL _____	_____
NEUROLOGICAL	NORMAL _____	ABNORMAL _____	_____
MUSCULOSKELETAL			
NECK/BACK	NORMAL _____	ABNORMAL _____	_____
SHOULDER/ARM	NORMAL _____	ABNORMAL _____	_____
ELBOW/WRIST/HAND	NORMAL _____	ABNORMAL _____	_____
HIP/THIGH	NORMAL _____	ABNORMAL _____	_____
KNEE	NORMAL _____	ABNORMAL _____	_____
LEG/ANKLE/FOOT	NORMAL _____	ABNORMAL _____	_____

I certify that the medical history information has been reviewed and the above-named individual has been given a thorough physical examination covering the above information. The above-named individual is (CHECK ONE BELOW):

	Withheld from participation	Explain: _____
	Limited participation	Explain: _____
	Cleared for unlimited participation – No restrictions	

MEDICATION STATEMENT

It is deemed medically necessary for this student to carry medication/inhaler on his/her person.

Name of medication 1:	Dosage:
Name of medication 2:	Dosage:
Condition(s) needing medication:	
PHYSICIAN'S SIGNATURE:	DATE:
PRINTED NAME AND BUSINESS PHONE NUMBER/STAMP	CALIFORNIA LICENSE NUMBER