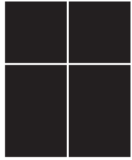

CATHOLIC DIOCESE OF WICHITA
424 NORTH BROADWAY • WICHITA, KANSAS 67202

OFFICE OF VOCATIONS
PHONE: (316) 269-3900 • FAX: (316) 269-3902

MEDICAL EXAMINATION OF APPLICANT BY PHYSICIAN

Name: ______________________________ Date: ______________________

1. Age: ________ Height: ________ Weight: ________ Build: Slender ________ Medium ________
Heavy ________ Obese ________

2. Blood Pressure: S ________ D ________ Urinalysis: Albumin ____________
Pulse: ________ Sugar ____________

3. Vision: Right 20/ ________ Left/20 ________ _____ with _____ without corrective lenses
Glasses: ________ Contact Lenses: ________ Color Vision: ________

Check each item in proper column	**Normal**	**Abnormal**
4. Head, neck face and scalp	________	________
5. Nose and sinuses	________	________
6. Mouth, teeth, gingiva and throat	________	________
7. Ears, canals, drums	________	________
8. Eyes-acuity, lids, pupils, motions	________	________
9. Lungs and chest	________	________
10. Heart	________	________
11. Vascular System (include varicosities)	________	________
12. Abdomen and Viscera (include hernia)	________	________
13. Ano-Rectal	________	________
14. Endocrine System	________	________
15. Genito-Urinary System	________	________
16. Upper Extremities	________	________
17. Lower Extremities (include feet)	________	________
18. Spine, other Musculo-Skeletal	________	________
19. Skin and Lymphatics	________	________
20. Neurological System	________	________
21. Psychiatric (Personality deviation, etc.)	________	________

22. Other ____

____

23. Any special tests used for your clinical evaluation? (Blood, EKG, etc.) ______________________

____

24. Comments or Recommendations: ______________________________

____

____

____

____

Please answer one of the following:

______ A. This student may participate in a program of physical education which includes such sports as basketball, soccer, swimming, gymnastics, tennis, handball, bowling and karate.

______ B. This student should be enrolled in a restricted program of physical education. I make this recommendation for this reason: ______________________________

____

____

Please submit copies or originals of the following:

1. HIV Blood screening
2. Blood screening, included with this physical
3. Copies of Immunization records retained in your office.
4. Drug test by urinalysis.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RECORDS

I hereby authorize any Physician, Hospital or Healthcare Specialist to release all medical information as well as copies of my medical records to the Roman Catholic Bishop of the Diocese of Wichita, Kansas or his representatives.

Dated, this ________ day of ________________ , 20 ____ ______________________________
Signature of Applicant

PHYSICIAN'S NAME:

____
please type or print

____
please type or print

Phone Number: ______________________

Street Address: ______________________

City, State, Zip: ______________________

Date: ______________________________