

**INSTITUTE OF NOTRE DAME**  
**Physical Information Form**

*This form must be returned by August 1<sup>st</sup>. No student will be permitted to attend orientation/classes and participate in the sports program until this form is completed and returned.*

**Part I – TO BE COMPLETED BY PARENT OR GUARDIAN**

Date: \_\_\_\_\_

Student's Name \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_  
(City) (State)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Telephone Number \_\_\_\_\_ Year of IND Graduation \_\_\_\_\_

.....  
List two neighbors or relatives who will assume temporary care of your daughter if you cannot be reached.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Full Name: \_\_\_\_\_ If living, age: \_\_\_\_\_

Condition of health: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

If deceased, cause of death and year: \_\_\_\_\_

Mother's Full Name: \_\_\_\_\_ If living, age: \_\_\_\_\_

Condition of health: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

If deceased, cause of death and year: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Student lives with: (check one)     Mother and Father     Mother     Father     Guardian

.....  
**Personal Information - Does your daughter have: (Yes or No)**

Diabetes: \_\_\_\_\_ Epilepsy or convulsive disorder: \_\_\_\_\_ History of Dizziness or fainting: \_\_\_\_\_

Asthma \_\_\_\_\_ Allergy: \_\_\_\_\_

Handicaps or chronic conditions: \_\_\_\_\_

Problems with vision/hearing requiring special seating: \_\_\_\_\_

List significant operations or injuries: \_\_\_\_\_

\_\_\_\_\_

- **Part I continued**

Psychological/Psychiatric/Eating Disorder: \_\_\_\_\_

List medications taken regularly and explain: \_\_\_\_\_

Menstrual History:

Age of onset: \_\_\_\_\_ Excessive bleeding: \_\_\_\_\_ Disabling pain: \_\_\_\_\_

Medication needed: \_\_\_\_\_ Explain \_\_\_\_\_

.....  
**PARENT CONSENT FORM** For administration of over-the-counter medications.

Student Name \_\_\_\_\_

Known Allergies \_\_\_\_\_

Medications taken regularly \_\_\_\_\_

Check the over-the-counter medications listed below that you wish available to your daughter in school.

- |                                    |           |          |
|------------------------------------|-----------|----------|
| 1. Acetaminophen (generic Tylenol) | Yes _____ | No _____ |
| 2. Ibuprofen (generic Advil)       | Yes _____ | No _____ |
| 3. Antacid (generic Tums)          | Yes _____ | No _____ |
| 4. Cough Drops                     | Yes _____ | No _____ |
| 5. Neosporin/bacitracin ointment   | Yes _____ | No _____ |
| 6. Hydrocortisone cream .5-1%      | Yes _____ | No _____ |

I give permission for my daughter to receive the above medications that I have checked during school hours to be administered by the school nurse.

**\*\*PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_

\*\*Please print parent/guardian name \_\_\_\_\_

**PART II – TO BE COMPLETED AND SIGNED BY PHYSICIAN**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse Rate: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Posture: \_\_\_\_\_

General Appearance: \_\_\_\_\_

Heart and Lungs: \_\_\_\_\_

Ears, Nose, and Throat: \_\_\_\_\_

Skin: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Extremities: \_\_\_\_\_

Student may participate in a complete physical education program: Yes \_\_\_\_\_ No \_\_\_\_\_

Student may participate in all athletic team sports: Yes \_\_\_\_\_ No \_\_\_\_\_

Does student need to use a wrap, brace, splint, inhaler, etc. for sports activity? \_\_\_\_\_

Explain any limitations: \_\_\_\_\_

**Immunization Record:** (Maryland State Law requires that this information be completed accurately).

	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
M/D/Y					
D.P.T.	(1) _____	(2) _____	(3) _____	(4) _____	(5) _____
Polio	(1) _____	(2) _____	(3) _____	(4) _____	(5) _____
MMR	(1) _____	(2) _____			
Hep B	(1) _____	(2) _____	(3) _____		
Varicella	(1) _____				



**PHYSICIAN AUTHORIZATION FORM FOR OVER THE COUNTER MEDICATIONS**

Student Name \_\_\_\_\_

Known Allergies \_\_\_\_\_

1. Acetaminophen (325mg) 1-2 tabs po q4hr prn                    yes \_\_\_\_\_                    no \_\_\_\_\_  
    (for headache, fever, mild muscle discomfort, menstrual cramps)
2. Ibuprofen (200mg) 1-2 tabs q4-6hr prn                            yes \_\_\_\_\_                    no \_\_\_\_\_  
    (for headache, mild to moderate muscle discomfort, menstrual cramps)
3. Antacid (Tums) 1-2 tabs po    yes \_\_\_\_\_                    no \_\_\_\_\_  
    (for mild to moderate gastric hyperacidity)
4. Cough drops 1-2 po prn    yes \_\_\_\_\_                    no \_\_\_\_\_  
    (for mild throat irritation or cough)
5. Bacitracin/Neosporin ointment topical                            yes \_\_\_\_\_                    no \_\_\_\_\_  
    (for minor cuts, skin abrasions)
6. Hydrocortisone cream 0.5-1% topical                            yes \_\_\_\_\_                    no \_\_\_\_\_  
    (for insect bites, mild rashes)

**\*\*PHYSICIAN SIGNATURE** \_\_\_\_\_

**\*\*DATE OF PHYSICAL** \_\_\_\_\_

**\*STAMP PHYSICIAN NAME, ADDRESS & PHONE NUMBER BELOW:**