



# Georgetown Preparatory School Physical Exam Form

To be completed and signed by a physician *Annual Requirement*

**School Year 2026-2027**

|                                                                                   |             |                                              |        |
|-----------------------------------------------------------------------------------|-------------|----------------------------------------------|--------|
| Last Name:                                                                        | First Name: | MI:                                          | DOB:   |
| Significant Medical History:                                                      |             |                                              |        |
| Date of Physical Examination:                                                     |             | Most Recent PPD Result/Risk assessment Date: |        |
| Height:                                                                           | Weight:     | BP:                                          | Pulse: |
| Restriction to participation in school/sports activities? NO YES (please explain) |             |                                              |        |
| Current Medications/Additional Comments:                                          |             |                                              |        |

The above-named student has my permission to receive the following over-the-counter medications or their generic alternative (please cross off any medications *not* allowed):

Tylenol, Sudafed, Mucinex, Robitussin, Advil, Claritin, Zyrtec, Benadryl, Tums, Pepto-Bismol, Bacitracin, Cortisone 10

|                               |       |
|-------------------------------|-------|
| Physician's Signature:        | Date: |
| Physician Name Printed:       |       |
| Office Stamp (address/phone): |       |

Health Office  
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