WILSON CENTRAL SCHOOL PRE-PARTICIPATION SPORTS PHYSICAL

Name_______________ Address_______________ Zip_________ Phone___________

Date of Birth_____________ Age________ Grade________ School Year__________ Student ID______________

Parent's Name_______________________

In case of emergency, notify: Name_____________________ Address_____________________

Phone______________ Hospital Preference____________________ Family Doctor______________________

Date of last tetanus booster____________________ Date of last examination by a doctor____________________

I UNDERSTAND THAT FAILURE TO ANSWER THE QUESTIONS BELOW ACCURATELY WILL DISQUALIFY ME FROM ANY SPORTS PARTICIPATION ______________________________ (Signature)

The following questions are to be answered by either yes or no. Please check the appropriate space.

	YES	NO
Have you been under a doctor's care in the past 12 months?	( )	( )
Have you been in the hospital in the past 12 months?	( )	( )
Have you ever had any type of surgery?	( )	( )
Do you want to talk to a doctor about a health Problem or an inury?	( )	( )
Has anyone in your immediate family ever had:		
Diabetes (high sugar in blood)?	( )	( )
Allergies (hay fever or asthma)?	( )	( )
Migraine Headaches?	( )	( )
Heart Trouble?	( )	( )
High Blood Pressure?	( )	( )
Has anyone in your family, under age 50, died suddenly?	( )	( )
Have you had or do you now have:		
Brain concussion (head injury)?	( )	( )
Tendency to lose consciousness (faint)?	( )	( )
Skull fractures?	( )	( )
Convulsions/epilepsy/seizures?	( )	( )
Neck injury?	( )	( )
Very bad (impaired) vision in one eye	( )	( )
Temporary loss of vision?	( )	( )
To wear glasses or contact lenses? (Circle)	( )	( )
Have you had or do you now have?		
Hearing loss?	( )	( )
Perforated eardrum?	( )	( )
Discharge from ear(s)	( )	( )
(recurrent infections)	( )	( )
Sinus infections?	( )	( )
Orthodontia (teeth straightened)	( )	( )
Hernia?	( )	( )
Kidney problems?	( )	( )
Heat exhaustion?	( )	( )
Mononucleosis?	( )	( )
Loss of function or absence of testicles (boys)?	( )	( )
Mentrual problems (girls)?	( )	( )
Age of onset of menstruation__________		
Month/Year of first menses__________		
Have you had or do you now have:		
Bone fracture?	( )	( )
Joint dislocation?	( )	( )
Nose Fracture?	( )	( )
List date & injury__________________		

	YES	NO
Have you had or do you now have:		
Back injury or frequent backaches?	( )	( )
Knee injury (sprain) or recurrent pain?	( )	( )
Ankle injury (sprain) or recurrent pain?	( )	( )
Other joint problems (e.g. swelling, pain Decreased range of motion?	( )	( )
Bone infection?	( )	( )
Arthritis?	( )	( )
Have you had or do you now have:		
Diabetes (high sugar in blood or urine)?	( )	( )
Tendency to bleed or bruise easily?	( )	( )
Anemia ("tired" blood)?	( )	( )
Nosebleeds frequent or severe? (Circle)	( )	( )
Asthma (wheezing)?	( )	( )
Medication:__________________		
Inhaler:__________________	( )	( )
Hay Fever?	( )	( )
Hives or rash?	( )	( )
Bee-sting reactions (allergy)?	( )	( )
Reaction to medicine	( )	( )
Name:__________________		
Other allergies? List __________________		
Do you:		
Smoke?		
Take any medicine regularly? If so,	( )	( )
Please list__________________		
Have you had or do you now have?		
Heart trouble or murmur?	( )	( )
High blood pressure?	( )	( )
Persistent cough?	( )	( )
Chest pain with exercise?	( )	( )
Dizziness or faintness with exercise?	( )	( )
Recurrent rash?	( )	( )
Fungus infection?	( )	( )
Athlete's foot?	( )	( )
Recurrent boild (skin infection)?	( )	( )
Do you wish to discuss an emotional problem with the doctor?	( )	( )
Have you ever been told to give up sports because of a health problem?	( )	( )

Recommended / Sample Form

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: ____________________ **Date of Birth:** ____________________

School: ____________________ **Gender:** ☐ M ☐ F **Grade:** ____________________

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐Negative ☐ Not done Date: __________
PPD: ☐ Positive ☐Negative ☐ Not done Date: __________
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: __________
Dental Referral ☐ Yes ☐ No ☐ Not done Date: __________

Significant Medical/Surgical History: ☐ See attached ____________________

Allergies: ☐ **LIFE THREATENING** ☐ Food: __________ ☐ Insect: __________ ☐ Other: __________
☐ Seasonal ☐ Medication: __________

PHYSICAL EXAM

Height: __________ Weight: __________ Blood Pressure: __________ Date of Exam: __________

Body Mass Index: ___ ___ . ___

Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: __________

Specify any abnormality (use reverse of form if needed): ____________________

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: ____________________ Dosage/Time: ____________________
Name: ____________________ Dosage/Time: ____________________

If AM dose is missed at home: ____________________

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** ____________________ ☐ None

☐ **Known or suspected disability:** ____________________ ☐ Please monitor

☐ **Restrictions:** ____________________ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: __________

Provider's Signature: ____________________ Phone: __________ (Stamp below)

Provider's Name/Address: ____________________ Fax: __________

Parent Signature: ____________________ Date: __________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 2/08*