BELLPORT MIDDLE/SENIOR HIGH SCHOOL
PHYSICAL FORM

NAME:________________________ BIRTH DATE:_____________ GRADE:_______

Participation in athletics is voluntary and is not required for the regular physical education program.

Please identify any sports in which you **DO NOT** wish your child to participate.

NOTE: IF YOU INTEND FOR THE STUDENT TO BE SEEN BY THE SCHOOL PHYSICIAN, THIS FORM MUST BE COMPLETED AND RETURNED BEFORE THE SCHEDULED APPOINTMENT.

HEALTH HISTORY TO BE COMPLETED BY PARENT

Please check:	YES	NO		YES	NO
allergy/hay fever	____	_____	elevated blood pressure	_____	_____
bee sting allergy	____	_____	bladder/kidney problem/injury	_____	_____
asthma	____	_____	head injury/concussion	_____	_____
anemia/sickle cell	____	_____	heart problem/murmur/chest pain	_____	_____
arthritis	____	_____	nosebleeds/frequent or severe	_____	_____
convulsions/seizures	____	_____	fracture/dislocation bones/joints	_____	_____
fainting spells	____	_____	back pain/injury	_____	_____
diabetes	____	_____	knee pain/injury	_____	_____
ankle injury	____	_____	ear problem/hearing loss	_____	_____
injury to spleen	____	_____	eye problem/vision loss	_____	_____
mononucleosis	____	_____	joint sprain/ligament tear muscle	_____	_____
headaches	____	_____	blood in urine/bowel	_____	_____
tuberculosis	____	_____	nose fracture	_____	_____
epilepsy	____	_____	stomach ulcer	_____	_____

Is your child assigned to the Adaptive Physical Education Program or has he/she been in an Adaptive Program? _____ _____

Has your child been unconscious or lost memory from a blow to the head? _____ _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING:
One eye or severe uncorrectable loss of vision - one or both eyes? _____ _____
Severe hearing loss in one or both ears? _____ _____
One kidney/one testicle? _____ _____
An illness for five consecutive days? _____ _____
If so, when/why?____
An illness, condition or injury that required him/her to go to the hospital, either as a patient overnight or the emergency room for x-rays? Required an operation? Missed a game/practice? _____ _____

IS YOUR CHILD UNDER MEDICAL CARE NOW? _____ _____
If so, for what?____
Has your child taken medication in the past year? _____ _____
If so, what medication?____
Is your child taking medication now? _____ _____
If so, what medication?____

Has your child ever fainted during exercise? _____ YES _____ NO

If so explain?____

Has there ever been a sudden death of a family member under the age of 50? _____ _____

Do you have any concerns you want to discuss with the doctor? _____ _____

DOES YOUR CHILD:

Have orthodontic appliances/capped teeth? _____ _____

Wear contact lenses/glasses/hearing aids for sports? _____ _____

Since your child's last physical examination has he/she had any significant injury or serious illness? _____ _____

If so, what?____

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school, including practice sessions and travel to and from athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by the school authorities.

PARENTS SIGNATURE________________________________DATE______________

EXAMINATION

Ht ________ Wt________ B/P_______ Urinalysis/Albumin_______Sugar_______Blood__________

Eyes (Fundi) R _________ L ________ Ears (Otoscoptic) R ______ L _______

Throat/Thyroid____________________ Respiratory/Lungs________________________________

Cardiovascular ____

Abdominal/Liver___________________ Spleen ________________Hernia__________________

Musculoskeletal____________________ Skin __________________ Teeth ________________

Most recent booster for: Tetanus ___________________ Polio ___________________________

Comments: ____

This certifies that ______________________________ is physically qualified to participate in the following categories of competition during the 20____ school year.

Any unmarked categories indicates DISQUALIFICATION in that particular group of sports activities.

CONTACT COLLISION	LIMITED CONTACT IMPACT	STRENUOUS NONCONTACT	NONSTRENUOUS NONCONTACT
__________	__________________	______________	_________________
FOOTBALL	BASEBALL	CROSS-COUNTRY	BOWLING
LACROSSE	BASKETBALL	TRACK & FIELD	GOLF
SOCCER	GYMNASTICS	TENNIS	
WRESTLING	SOFTBALL		
	VOLLEYBALL		

______________________________ ______________________________

Physician's Signature Date of Examination

______________________________ ______________________________

Physician's Address Telephone Number

7/22/03 mr