

BELLPORT MIDDLE/SENIOR HIGH SCHOOL

NYSED requires an ANNUAL physical exam for NEW entrants, students in GRADES 7 and 10, SPORTS and WORKING PERMITS

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:
 TDAP _____ Varicella _____

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: _____ Urine: Albumin _____ Sugar: _____ Date of Exam: _____ Referral

| | | | | |
|--|--|---|---|--|
| Body Mass Index: _____ | Vision - without glasses/contact lenses | R | L | |
| Weight Status Category (BMI Percentile): | Vision - with glasses/contact lenses | R | L | |
| <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th | Vision - Near Point | R | L | |
| <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher | Hearing <input type="checkbox"/> 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: _____

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: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

**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: | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> |
|--------------------------------|------------|-----------|---------------------------------|------------|-----------|
| Bladder/kidney problem/injury | _____ | _____ | Head injury/concussion | _____ | _____ |
| Anemia/sickle cell | _____ | _____ | Heart problem/murmur/chest pain | _____ | _____ |
| Seizures | _____ | _____ | Fainting spells | _____ | _____ |
| High blood pressure | _____ | _____ | Diabetes | _____ | _____ |
| Headaches | _____ | _____ | One kidney/one testicle | _____ | _____ |
| Legally blind/one or both eyes | _____ | _____ | Eye problem/vision loss | _____ | _____ |
| Ear problem/hearing loss | _____ | _____ | Any recent injuries: _____ | _____ | _____ |
| Asthma | _____ | _____ | Uses inhaler | _____ | _____ |

Please list allergies: _____ Is an Epi-pen required? _____

Describe allergic reaction: _____

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

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

Has your child ever fainted during exercise?
If so, explain: _____

HAS YOUR CHILD had any recent illnesses requiring hospitalization/operations within the past year?
If so, explain: _____

IS YOUR CHILD UNDER MEDICAL CARE NOW?
If so, for what? _____

Has your child taken medication in the past year?
If so, what medication? _____

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? _____

I agree with the above answers and consent to my child's participation in the interscholastic program of his/her school, including practice session 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.

PARENT SIGNATURE: _____ DATE: _____