

*Sachem Central School District*

**Physical Examination Form**

Date of Examination \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_, 20\_\_\_\_  
Last First

Address \_\_\_\_\_ Family Physician \_\_\_\_\_ Phone \_\_\_\_\_  
No. Street Town Zip

Gender:  Male  Female

**IMMUNIZATIONS / HEALTH HISTORY**

Immunization Record Attached Sickle Cell Screen:  Positive  Negative  Not Done Date: \_\_\_\_\_  
 No Immunizations Given Today PPD:  Positive  Negative  Not Done Date: \_\_\_\_\_  
 Tetanus Date: \_\_\_\_\_ Elevated Lead:  Yes  No  Not Done Date: \_\_\_\_\_

Immunizations Given Since Last Health Appraisal: \_\_\_\_\_

Dental Referral:  Yes  No  Not Done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See Over \_\_\_\_\_

Allergies:  LIFE THREATENING  Food \_\_\_\_\_  Insect \_\_\_\_\_  Seasonal \_\_\_\_\_  
 Medication \_\_\_\_\_  Other \_\_\_\_\_

**PHYSICAL EXAM**

<input type="checkbox"/> Check here if entire exam normal	Height _____	Weight _____	Blood Pressure _____	
Body Mass Index _____	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile)	Vision - with glasses/contact lenses	R	L	
less than 5th	5th through 49th	50th through 84th	Vision - Near Point	R
85th through 94th	95th through 98th	99th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	

<b>Specify Current Diseases:</b>	<b>Check (√) Equals Normal Finding:</b>
<input type="checkbox"/> Asthma	Skin:
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	Lungs:
<input type="checkbox"/> Hyperlipidemia	Heart:
<input type="checkbox"/> Hypertension	Hernia:
Scoliosis: Negative _____ Positive: _____	Extremities:
Urinalysis: Protein _____ Sugar _____	Tanner: I. _____ II. _____ III. _____ IV. _____ V. _____

Specify any abnormalities: \_\_\_\_\_

**MEDICAL APPROVAL RECOMMENDED**

SPORTS CATEGORIES: Sports participation in the following categories is recommended as follows for one calendar year: Date \_\_\_\_\_ to \_\_\_\_\_

(Please initial all that apply):

- CONTACT/COLLISION (Field Hockey, Football, Lacrosse, Soccer, Wrestling)
- LIMITED CONTACT/IMPACT (Baseball, Basketball, Diving, Gymnastics, Softball, Volleyball)
- STRENUOUS NON-CONTACT (Cross Country, Track & Field, Swimming, Tennis, Cheerleading, Kickline/Dance)
- NON-STRENUOUS/NON-CONTACT (Bowling, Golf)

For unmarked categories, state reasons and provide medical conditions below.

Indicate Name of sport by season: Fall: \_\_\_\_\_ Winter: \_\_\_\_\_ Spring: \_\_\_\_\_

**PHYSICIAN INFORMATION:** Name of Physician (Print/Type/Stamp) \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

**Preparticipation Physical Examination Questionnaire**

*To be completed and signed by a parent or guardian*

- |                                                                                                                                                                                                              | YES                      | NO                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery?                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken any supplements or vitamins to help you improve your performance?                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a rash or hives develop during or after exercise?                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been dizzy or passed out during or after exercise?                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had chest pain during or after exercise?                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had high blood sugar (diabetes)?                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been diagnosed with anemia?                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had racing of your heart or skipped heartbeats?                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had high blood pressure?                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever been told you have a heart murmur?                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has any family member or relative died of heart problems or of sudden death before age 50?                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you had a severe viral infection?                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has a physician ever denied or restricted your participation in sports for any heart problems?                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever been diagnosed with blood or bleeding disorders?                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had a kidney or bladder problem (absence of a paired organ)?                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a head injury or concussion?                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been knocked out, become unconscious, or lost your memory?                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever had a seizure or convulsion?                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you have frequent or severe headaches?                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you cough, wheeze, or have trouble breathing during or after activity that prevents you from playing?                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have asthma or lung disease?                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have seasonal allergies that require medical treatment?                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you ever had any problem with your ears or hearing?                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you tire more easily than you feel you should?                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                                                                                                                                                                                    |                                  |                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------|
| 30. Have you ever had any problem with your eyes or vision?                                                                                                                                        | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 31. Have you ever had dental health problems?                                                                                                                                                      | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 32. Have you broken or fractured any bones or dislocated any joints, or been diagnosed with a stress fracture?                                                                                     | <input type="checkbox"/>         | <input type="checkbox"/>           |
| 33. Have you ever had a sprain, strain, or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports? | <input type="checkbox"/>         | <input type="checkbox"/>           |
| <i>If yes, check appropriate box and explain below.</i>                                                                                                                                            |                                  |                                    |
| <input type="checkbox"/> Head                                                                                                                                                                      | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| <input type="checkbox"/> Neck                                                                                                                                                                      | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| <input type="checkbox"/> Back                                                                                                                                                                      | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| <input type="checkbox"/> Chest                                                                                                                                                                     | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder                                                                                                                                                                  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Upper Arm                                                                                                                                                                 |                                  | <input type="checkbox"/> Foot      |

**FEMALES ONLY**

- |                                                                                                   |                          |                          |
|---------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 34. Has there been a recent change in menstrual patterns?                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. At what age did you experience your first menstrual period?                                   |                          |                          |
| 36. When was your most recent menstrual period? ___/___/___                                       |                          |                          |
| 37. How much time do you usually have from the start of one period to the start of another? _____ |                          |                          |
| 38. How many periods have you had in the last year? _____                                         |                          |                          |
| 39. What was the longest time between periods in the last year? _____                             |                          |                          |

**Explain "Yes" Answers Here (Identify each answer with question number)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RISK ACKNOWLEDGEMENT FORM**

I give permission for \_\_\_\_\_ to participate in any sports for which the examining physician or school nurse have determined there are no disqualifying conditions. I fully understand that my child may not participate in any practice, scrimmage or contest without proper medical clearance.

Further, I acknowledge that with participation in interscholastic athletics comes the risk of injury. These risks vary from sport to sport and can range from minor to catastrophic in nature. In addition, I also recognize that there are risks involved with team travel to contest sites at opposing school facilities.

I give permission for my child to undergo a medical examination by district approved physicians. If I choose to have the examination performed by a family physician, then I agree to have the information completed on the appropriate school forms. I also agree that in some cases, district appointed physicians shall have the right to review the information provided by family physicians and retain the right of final approval.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_