

Sachem Central School District

Physical Examination Form

Date of Examination _____ School _____

Name _____ Phone _____ Grade _____ Birth Date _____, 20__

Address _____ Family Physician _____ Phone _____

Gender: Male Female

IMMUNIZATIONS / HEALTH HISTORY

Immunization Record Attached
 No Immunizations Given Today
 Tetanus Date: _____
 Sickle Cell Screen: Positive Negative Not Done Date: _____
 PPD: Positive Negative Not Done 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

Check here if entire exam normal _____ Height _____ Weight _____ Blood Pressure _____

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

Specify Current Diseases:

Asthma
 Diabetes Type 1 Type 2
 Hyperlipidemia
 Hypertension
 Scoliosis: _____ Negative _____ Positive: _____
 Urinalysis: Protein _____ Sugar _____

Check (✓) Equals Normal Finding:

Skin: _____
 Lungs: _____
 Heart: _____
 Hernia: _____
 Extremities: _____
 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 _____

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 require review by private healthcare provider and the school medical director.

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"/> | 30. Have you ever had any problem with your eyes or vision? | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had dental health problems? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Have you ever had surgery? | <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"/> |
| 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"/> | 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? <i>If yes, check appropriate box and explain below.</i> | <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"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Hip |
| 6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm |
| 7. Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist |
| 8. Have you ever been dizzy or passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand |
| 9. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger |
| 10. Have you ever had high blood sugar (diabetes)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Ankle |
| 11. Have you ever been diagnosed with anemia? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Foot | |
| 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"/> | | |

FEMALES ONLY

34. Has there been a recent change in menstrual patterns?
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 has 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 _____