Sports Participation Medical History (To be completed by Parent/Guardian)

Name:_____ Grade:___ Age:_____ Date:_____

Dear Parents: We want to assure, as well as possible, your child's safety for sport's participation. Please complete the following medical history about your child:

1: Has he/she had any serious illness or injury since their last regular or sport physical exam? __No __Yes

2: Have any family members under age 50 had a heart attack, heart problems, or died suddenly of causes other than an accident? __No __Yes

3: Have he/she ever been told they have a heart murmur, high blood pressure, extra heart beats, or a heart abnormality? __No __Yes

4: Is he/she missing any organs (eye, kidney, spleen, testicle, etc.)? __No __Yes

5: Has he/she ever had chest pain, fainting, or dizziness with exercise? __No __Yes

6: Has he/she ever "passed out", been "knocked out"(concussion), had trouble with heat exhaustion, or had seizures(convulsions)? __No __Yes

7: Is he/she on any regular medications, supplements, or performance enhancing medicines? __No __Yes

8: Does he/she have to stop while running twice around a standard track (400 meters / *a* mile)? __No __Yes

9: Other than a minor flu or other common medical illness, has he/she ever had an illness, injury or condition that:

- A: Required hospitalization, emergency room treatment, or x-ray> __No __Yes
- B: Required an operation? __No __Yes
- C: Lasted longer than a week? __No __Yes
- D: Caused you to miss a game or practice? __No __yes
- E: Is related to allergies (asthma, hay fever, hives, medicine)? __No __Yes

10: Does he/she wear glasses, contacts, have false teeth or use other medical or protective appliances? __No __Yes

11: Are you concerned about his/her weight? (or weight loss for sport?) __No __Yes

12: (Female only) Are her periods regular? Does she have menstrual problems? __No __Yes

Further Information on "Yes" Answers:

Your signature below gives permission to allow our school physician to perform the physical exam, free of charge.

_____ (Signature)

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name: Sex: ☐ M ☐ F DOB:

School: Grade: Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Parent Signature to have physical done by school doctor here. X _____ Date: _____

Name:			DOB:
SCREENINGS			
Vision	**Right**	**Left**	**Referral** / **Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No
Distance Acuity With Lenses	20/	20/	
Vision – Near Vision	20/	20/	
Vision – Color ☐ Pass ☐ Fail			
Hearing	Right dB	Left dB	Referral
Pure Tone Screening 20 dB			☐ Yes ☐ No
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No
Deviation Degree:	Trunk Rotation Angle:		

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain:

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.