

MEDICAL HEALTH FORM Required for Grades 7, 10 and new entrants. Failure to return this medical report will result in the school physician examining your child. **ORIGINAL MUST BE DATED AFTER APRIL 1st TO BE USED FOR INTERSCHOLASTIC SPORTS GRADES 7-12.**

NAME _____ GRADE _____

ADDRESS _____

Date of Birth _____ Age _____ Male Female

PARENT'S NAME (or Guardian)

Mother _____

Name

Phone/Home _____ Business _____ Beeper/cell _____

Father _____

Name

Phone/Home _____ Business _____ Beeper/cell _____

PHYSICIAN to be called in emergency:

Name _____ Phone _____

PERSON other than parent to be called in emergency:

Name/Relationship _____ Phone _____

HEALTH HISTORY (TO BE COMPLETED BY PARENT)

Allergies _____ Heart Disease _____

_____ Kidney Disease _____

_____ Mononucleosis _____

Asthma _____ Diabetes _____

Congenital Defect _____ Seizure Disorder _____

_____ Strep/Scarlet Fever _____

Other _____

DATES AND DESCRIPTIONS

Operations _____

Serious Injuries _____

IMMUNIZATIONS - Given this calendar year

(TO BE COMPLETED BY PHYSICIAN)

Initial Series _____ Measles _____

DPT 1st _____ Mumps _____

2nd _____ Rubella _____

3rd _____ MMR #1 _____

TDAP _____ MMR #2 _____

DT 1st _____ HIB _____

2nd _____ Polio 1st _____

3rd _____ 2nd _____

or Boosters: _____ 3rd _____

HEP. B _____ Boosters: _____

_____ TB (PPD) _____ Results _____

_____ HIB _____

Varicella _____ Varicella Disease _____

TO BE COMPLETED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN NEW YORK STATE

GRADES 7-12 COMPLETE FOR SPORTS PHYSICAL*

Resting Pulse* _____ BMI _____ % _____

Blood Pressure* _____ / _____ Eyes _____

Height* _____ Weight* _____

Lymph Nodes _____ Thyroid _____

Nose _____ Tonsils _____

Heart _____ Lungs _____

Hernia _____ Genito-urinary _____

Ortho-Struc. _____ Scoliosis _____

Feet _____ Skin (non-comm.) _____

Seizure Disorder _____ Other _____

Defects (specify) _____

Recommendations _____

Hearing R _____ L _____

Vision R 20/ _____ L 20/ _____

W/Glasses R20/ L20/ W/Contacts R20/ L20/

SEVERE MYOPIA (20/200 OR MORE EITHER EYE)

REQUIRES OPHTHALMOLOGICAL CLEARANCE FOR

CONTACT SPORTS.

STUDENT CAN PARTICIPATE IN ALL INTER-SCHOLASTIC CONTACT/COLLISION SPORTS WITHOUT RESTRICTION.

Physician's Signature _____

Physician's Name Printed _____

Physician's Address _____

_____/_____/_____
DATE OF EXAM* _____ Phone Number _____

MUST BE DATED AFTER APRIL 1st.

MAIL TO: HEALTH OFFICE
Roslyn High School
Round Hill Road
Roslyn Heights, NY 11577

****TO BE COMPLETED BY PARENT REQUESTING SCHOOL PHYSICAL:**

I give permission for my son/daughter to be examined by the School Physician.

Parent's Signature _____

Date _____

Co signature School Physician _____

Date _____