ROSLYN PUBLIC SCHOOLS 2018/2019 ROSLYN MIDDLE SCHOOL

MEDICAL HEALTH FORM is required by New York State for all Grades 7 students and all new entrants.
Failure to return a medical report will result in the school physician examining your 7th grade child.
THIS FORM MUST BE USED FOR INTERSCHOLASTIC SPORTS GRADES 7-8

NAME_____ GRADE_____
ADDRESS _____
Date of Birth_____Age____ ☐ Male ☐ Female
PARENT'S NAME (or Guardian)
Mother_____
Name
_____
Phone/Home Business Cell
Father_____
Name
_____
Phone/Home Business 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_____
Chicken Pox_____	Seizure Disorder_____
Congenital Defect_____	Strep/Scarlet Fever_____

MEDICATIONS:_____

DATES AND DESCRIPTIONS
Operations _____
Serious Injuries _____

IMMUNIZATIONS – Given this calendar year
(TO BE COMPLETED BY PHYSICIAN)

Initial Series			
DPT	1st_____	Measles_____	
	2nd_____	Mumps_____	
	3rd_____	Rubella_____	
TDAP	_____	MMR #1_____	
DT	1st_____	MMR #2_____	
	2nd_____	HIB _____	
	3rd_____	Polio 1st_____	
or Boosters:_____		2nd_____	
HEP. B_____		3rd_____	
_____		Boosters:_____	
Varicella:#1_____		Meningococcal: #1_____	
#2 _____		#2_____	

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

GRADES 7-8 COMPLETE FOR SPORTS PHYSICAL*

Pulse_____BMI_____WSC_____% MD *must provide*
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 OPTHALMOLOGICAL 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*

THE EXAM MUST BE COMPLETED

Physician Stamp:

MAIL TO: HEALTH OFFICE
Roslyn Middle School
375 Locust Lane
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 on

Parent's Signature _____ Date _____

Co signature School Physician _____ Date _____