

MEDICAL HEALTH FORM is required by New York State for all Grades 10 students and all new entrants. Failure to return a medical report will result in the school physician examining your 10th grade child. THIS FORM MUST 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 _____ 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 _____ 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: _____

_____ Meningococcal: #1 _____

Varicella: #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 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*

THE EXAM MUST BE COMPLETED AFTER APRIL 1, 2017

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 Wednesday, June 8, 2017 @2:30pm

Parent's Signature _____

Date _____

Co signature School Physician _____

Date _____