

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT

NAME _____ GENDER _____ GRADE _____ BIRTHDATE _____

HEALTH HISTORY (to be completed by a parent/guardian) SPORT _____

- | | | |
|---|------------------------------|-----------------------------|
| 1. Have you had a head injury, concussion, seizure or been unconscious in the past year? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Have you been hospitalized, treated in the emergency room or had surgery in the past year? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Do you have any allergies (medication, food or bee sting)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Do you have asthma? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Have you had any fractures, dislocations, severe sprains or serious injuries? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Have you ever been refused permission to participate in athletics? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Do you wear glasses or contact lenses? Braces? Dental plate or bridge? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Have you ever had a heart murmur, high blood pressure or heart abnormality? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you ever been dizzy or passed out after exercise? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Do you have any chronic illnesses? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Are you under a doctor's care at this time? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

12. List all medications you are presently taking and reason or condition: _____

PLEASE EXPLAIN ANY "YES" ANSWERS TO THE QUESTIONS ABOVE

To the best of my knowledge, the above information is correct:

SIGNATURE: _____ DATE: _____

HEALTH EXAMINATION (to be completed by a Physician) **Actual readings required*

*Height _____ *Weight _____ *Blood Pressure _____ *Pulse _____ *Scoliosis _____

*Body Mass Index: _____

*Weight Status Category (MBI Percentile):

- | | | |
|--|--|--|
| <input type="checkbox"/> Less than 5th | <input type="checkbox"/> 5th through 49th | <input type="checkbox"/> 50th through 84th |
| <input type="checkbox"/> 85th through 94th | <input type="checkbox"/> 95th through 98th | <input type="checkbox"/> 99th and higher |

EXAM WITHIN NORMAL LIMITS

Specify any abnormality: _____

Specify current diseases: Asthma Diabetes Type 1 Diabetes Type 2 Cholesterol Hypertension

Allergies:

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Seasonal | <input type="checkbox"/> Life Threatening |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Medication |

Medications: _____

FOR INTERSCHOLASTIC COMPETITIVE ATHLETIC ACTIVITIES:

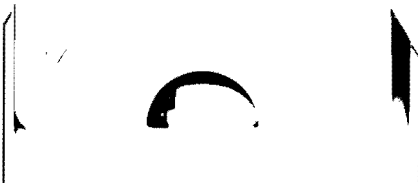
THIS CERTIFIES THAT THE ABOVE NAMED STUDENT IS PHYSICALLY QUALIFIED TO PARTICIPATE IN THE FOLLOWING CATEGORIES OF COMPETITION THIS SCHOOL YEAR (to be completed by the physician):

Contact/Collision	Limited Contact/Impact	Strenuous/Non contact	Nonstrenuous/Non contact
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Football	Baseball Gymnastics	Cross-country	Bowling
Lacrosse	Basketball Kickline	Track & Field	Golf
Soccer	Cheerleading Softball	Swimming	
Wrestling	Diving Volleyball	Tennis	

Reason for disqualification: _____

DATE OF PHYSICAL: _____

PHYSICIAN'S SIGNATURE: _____



REQUIRED IMMUNIZATIONS

DIPHTHERIA, PERTUSSIS, TETANUS

TREATMENT **TYPE** **mo/day/yr**

Dose: _____

Dose: _____

Dose: _____

Booster: _____

Booster: _____

PERTUSSIS BOOSTER (one dose required for children born after 1/1/94 and enrolling in 6th grade)

TYPE **mo/day/yr**

POLIOMYELITIS (min. 3 full dates required)

TREATMENT **TYPE** **mo/day/yr**

Dose: _____

Dose: _____

Dose: _____

Booster: _____

Booster: _____

MEASLES MUMPS, RUBELLA

(Measles - 2 full dates, Mumps - 1 full date, Rubella - 1 full date **OR** MMR - 2 full dates)

TYPE **mo/day/yr**

HEPATITIS B (3 doses required)

TYPE **mo/day/yr**

VARICELLA (Minimum 1 dose)

TYPE **mo/day/yr**

HIB (1 dose given on or after 15 mo. of age or 3 doses given prior to 15 mo. of age)

TYPE **mo/day/yr**

OPTIONAL IMMUNIZATIONS

MENINGITIS

TYPE **mo/day/yr**

HEPATITIS A

TYPE **mo/day/yr**

GARDASIL

TYPE **mo/day/yr**

OTHERS

TYPE **mo/day/yr**

MOST RECENT TB SCREENING

TYPE **mo/day/yr** **Result**

CHILDHOOD DISEASES

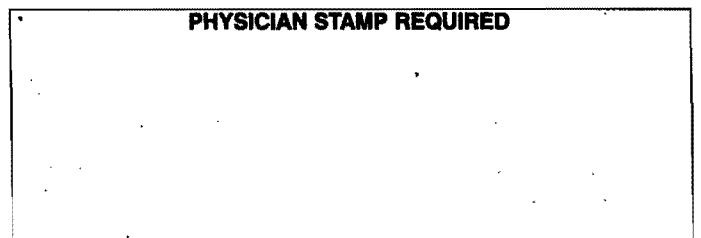
mo/day/yr

Chicken Pox _____

Others: _____

Physicians's (or examiner's) signature (& title): _____

Date: _____



LEGAL REQUIREMENTS FOR IMMUNIZATIONS WAIVED BECAUSE OF:

- a. Parental religious exemption _____
(written statement attached)
- b. Physician's medical exemption _____
(written statement attached)

