BOARD OF COOPERATIVE EDUCATIONAL SERVICES OF NASSAU COUNTY 05/09
HEALTH AND ALLIED SERVICES

PHYSICAL EXAMINATION

STUDENT______________________________ BIRTH DATE________________ DATE OF EXAM __________

PHYSICAL EXAMINATION: Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school district and all children in grades K, 2, 4, 7 and 10 will be examined by the school physician if no report is received.
***An annual physical examination is required for participation in interscholastic sports. (*Both sides must be completed.)**

1. BP_________ Pulse _________
2. Height _________Weight _________
   Body Mass Index:_____ _____ . _____
   Weight Status Category (BMI Percentile)
   ☐less than 5th ☐5th- 49th ☐ 50th- 84th
   ☐85th- 94th ☐95th- 98th ☐99thand higher
3. Urinalysis_______________________
4. Heart __________________________
5. Breasts __________________________
6. Lungs __________________________
7. Eyes R ___________ L ____________
   With Glasses R _________ L ________
8. Visual Diagnosis __________________
9. Ears: Otoscopic __________________
   Audiometric ________________
   P.E. tubes Yes ____ No _____
10. Speech________________________________
11. Nose ________________________________
12. Throat ________________________________
13. Tonsils ______________________________
14. Teeth and gums ________________________
15. Skin ________________________________
16. Glands (cervical, thyroid, other) ___________
17. Nervous system ________________________
18. Hernia ________________________________
19. Genitourinary ___________________________
20. Tanner I. II. III. IV. V.
21. Orthopedic: scoliosis: ☐ positive ☐ negative
    posture ______ feet ______
    structural defects_____________
22. Abdomen ______________________________

SURGERIES: ____

SIGNIFICANT ILLNESSES / INJURIES: ____

ALLERGIES: ____

ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM

Full Activity________ Restriction________ Recommendation__________________________________

CURRENT MEDICATIONS (please list all medications and dosages):

____

IMMUNIZATIONS (*please fill in or attach record of immunization*) PROCEDURES / TESTS

DPT or DTaP_______/_______/_______ (3 required)
Td or DT Booster__________________
Tdap ___________________
Polio (OPV or IPV) ______/______/____ (3 required)
PCV _____/______/_______/_________

MMR___________/____________ (2 measles required for Kindergarten)
Varicella________/____________
HIB ______/______/______/______
Hep B_______/_______/_______ (3 required)
Other______________________

TB Screening_________________
Chest X-ray_________________
Sickle Cell Test_______________
Lead Test_______________ (Required for Pre School)

______________________________ __________ ______________________________
Signature of Examining Physician Date Print Name

Physician's Address & Phone #
(PLEASE STAMP)

INTERSCHOLASTIC SPORTS HEALTH EXAMINATION

Please complete both sides for participation in interscholastic sports.

This certifies that ____ is physically qualified to participate in the following categories of competition during this school year **except** those crossed out below.

CONTACT / COLLISION	LIMITED CONTACT / IMPACT	STRENUOUS NON-CONTACT	NON-STRENUOUS / NON-CONTACT
Field Hockey Football Ice Hockey Lacrosse Soccer Wrestling	Baseball Basketball Cheerleading Diving Gymnastics Handball Skiing Cross Country Downhill Softball Volleyball	Crew Cross Country Track & Field Swimming Tennis	Archery Bowling Golf Riflery

Physician
Signature: ____ Date:____________
Family Physician

- Sport

The school physician has the final responsibility for the determination of a student's physical eligibility to participate in interscholastic sports. This is in compliance with the State Education Department Regulation 135.4 (7) (h).

Physician
Signature: ____ Date: ____________
School Physician

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I give my child permission to participate on all interscholastic athletic teams at school **except**:

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Signature: ____ Date: ____________
Parent / Guardian