Cato-Meridian Central School

Grade ________________

Age _________________

ATHLETIC HEALTH HISTORY

Name:____ Birth Date: ________________

Participation in athletics is voluntary and is not a required part of the regular physical education program.

SPORTS ACTIVITIES

Identify any sports in which you do not wish your child to participate:

____

THIS FORM MUST BE COMPLETED AND RETURNED ON THE DAY THE ATHLETE HAS HIS/HER PHYSICAL. THE APPOINTMENT DATE FOR THE PHYSICAL EXAINATION IS IN THE UPPER LEFT HAND CORNER.

HEALTH HISTORY
TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever	❒	❒	Elevated Blood Pressure	❒	❒
Bee Sting Allergy	❒	❒	Headaches	❒	❒
Asthma	❒	❒	Head Injury/Concussion	❒	❒
Anemia	❒	❒	Heart Problem/Murmur-Chest pain	❒	❒
Arthritis	❒	❒	Nose Bleeds/Frequent or Severe	❒	❒
Bladder/Kidney Problem or Injury	❒	❒	Ankle Injury	❒	❒
Convulsions/Seizures	❒	❒	Back Pain/Injury	❒	❒
Fainting Spells	❒	❒	Fracture-Dislocation Bones/Joints	❒	❒
Diabetes	❒	❒	Knee Pain/Injury	❒	❒
Ear Problems/Hearing Loss	❒	❒	Neck Injury	❒	❒
Eye Problems/Vision Loss	❒	❒	Nose Fracture	❒	❒
Injury to the Spleen	❒	❒	Rheumatic Fever	❒	❒
Joint Sprain/Ligament Tear/Muscle Pull	❒	❒	Stomach Ulcer	❒	❒

	YES	NO
Is there a current medical examination on file in the nurse's office:	❒	❒
Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?	❒	❒
Has your child been unconscious or lost memory from a blow on the head?	❒	❒

(continued)

History Continued

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes……………………….	❒	❒
Severe hearing loss in both ears…………………………………………………………	❒	❒
One kidney………………………………………………………………………………	❒	❒
One testicle………………………………………………………………………………	❒	❒
Has your child been ill for five (5) consecutive days?……………………………………	❒	❒

____

____

	YES	NO
Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice?_______________________	❒	❒

____

	YES	NO
Is your child under medical care now?…………………………………………………….	❒	❒
Has your child taken any medication in the past year?…………………………………….	❒	❒

If so, why?____

____

____

____

	YES	NO
Is your child taking any medications now?………………………………………………..	❒	❒

If so, why?____

____

	YES	NO
Has your child ever fainted during exercise?………………………………………………	❒	❒
If so, explain.____		
Has there ever been sudden death in a family member under fifty (50) years of age?…….	❒	❒

____

	YES	NO
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?……………………………………………………………………….	❒	❒
Does your child have: orthodontic appliances?……………………………………………	❒	❒
Capped teeth?…………………………………………………………………………….	❒	❒
Wear contact lenses for sports?…………………………………………………………….	❒	❒
Wear glasses for sports?……………………………………………………………………	❒	❒
Since your child's last physical examination, has your child had any injury or illnesses?..	❒	❒

____

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT SIGNATURE:____________________________________**Date**:____________________

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: ______________________________ **Date of Birth:** ______________________

School: ______________________ **Gender:** ❑ M ❑ F **Grade:** ______________________

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: ____________
PPD: ❑ Positive ❑ Negative ❑ Not done Date: ____________
Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: ____________
Dental Referral ❑ Yes ❑ No ❑ Not done Date: ____________

____

Significant Medical/Surgical History: ❑ See attached ______________________________________

____

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension
❑ Other: ______________________________________

Allergies: ❑ **LIFE THREATENING** ❑ Food: ____________ ❑ Insect: ________________ ❑ Other: ________________

❑ Seasonal ❑ Medication: ______________________________ ________________

PHYSICAL EXAM

Height: ____________ Weight: ____________ Blood Pressure: ______/_______ Pulse: _________ Date of Exam: __________________

Urine: ❑ Negative ❑ Positive

Body Mass Index: _____ _____ . _____ Weight Status Category (BMI Percentile): ❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th ❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher				*Referral*
	Vision - without glasses/contact lenses	R	L	
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❑ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❑ Negative ❑ Positive: ______________
____

Specify any abnormality (use reverse of form if needed): ______________________________________

____

____

MEDICATIONS

Medications (list all): ❑ None ❑ Additional medications listed on reverse of form

Name: ______________________________ Dosage/Time: ______________________________

Name: ______________________________ Dosage/Time: ______________________________

If AM dose is missed at home: ____

I assess this student to be self-directed ❑ Yes ❑ No Student may self carry and self administer medication ❑ Yes ❑ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❑ **Specify medical accommodations needed for school**: ______________________________ ❑ None

❑ **Known or suspected disability:** ______________________________ ❑ Please monitor

❑ **Restrictions:** ______________________________ ❑ Please monitor

❑ **Protective equipment required:** ❑ Athletic Cup ❑ Sport goggles/impact resistant eyewear ❑ Other: ________________

Provider's Signature: ______________________________ Phone: ________________ (Stamp below)

Provider's Name/Address: ______________________________ Fax: ________________

Parent Signature: ______________________________ Date: ________________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 10/3/07