Return to Health Office

BOARD OF COOPERATIVE EDUCATIONAL SERVICES OF NASSAU COUNTY 3/11
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)*

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_____

PROCEDURES / TESTS

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).

This student is cleared for participation in interscholastic sports as indicated above.

Physician
Signature: ____ Date: ____________

School Physician