

HEALTH EXAMINATION RECORD
Valley Stream High School District

Name _____ Sex _____ Grade _____ Age _____ School _____

PART I - TO BE COMPLETED BY PARENT

HISTORY

	Date		Date		Date		Date
Anemia	_____	Heart Disease	_____	Rheumatic Fever	_____	Asthma/Allergies	_____
Chicken Pox	_____	Measles	_____	Scarlet Fever	_____	Ear Conditions	_____
Diabetes	_____	Mumps	_____	Tuberculosis	_____	Frequent Colds &	_____
Epilepsy	_____	Nephritis	_____	TBC contacts	_____	Sore Throats	_____
German Measles	_____	Pneumonia	_____	Whooping Cough	_____	Operations	_____

Any medical condition presently being treated _____

Any medication presently taking _____

Any allergies _____

Any previous medical condition _____

Anything you think we should know about your child's health _____

PART II - TO BE COMPLETED BY PERSONAL PHYSICIAN AT TIME OF EXAM

Preventive measures and tests: The Public Health Law Section 2164 now mandates immunization against diphtheria, polio, tetanus, varivax, Tdap, measles, mumps, rubella (German Measles) and Hepatitis B. Indicate *dates* for the following preventive measures and tests.

DPT: 1. _____ 2. _____	IPV/OPV:	Hepatitis B:
3. _____ Booster _____	1st _____	1. _____
Tetanus _____ Tdap _____	2nd _____	2. _____
Measles Vac. (Live) _____	3rd _____	3. _____
German Measles Vac. _____	Booster _____	H.I.B. _____
Mumps Vac. _____	Hepatitis A	Varivax 1. _____ 2. _____
Second Measles _____	1. _____	Chest X-Ray _____
MMR _____	2. _____	Result _____
PREVNAR _____	Tine/Mantoux _____	Menactra _____
	Result _____	HPV _____

Height: _____ Weight: _____ BMI: _____ %: _____

Hearing R: _____ L: _____

Vision R: _____ L: _____

Vision Correction R: _____ L: _____

Blood Pressure _____ Pulse _____

Nutrition _____

Teeth _____

Nose _____

Skin _____

Speech _____

Hernia _____

Genito-Urin. _____

Urine Analysis _____

Tanner Maturity _____

Glands: Cervical _____

Thyroid _____

Other _____

Heart _____

Lungs _____

Orthopedic: Structural _____

Posture _____

Scoliosis Screening _____

Nervous System _____

(Specify if convulsive disorder)

Fine Motor _____

Gross motor _____

Any existing medical condition _____

General Condition: Good _____ Fair _____ Poor _____

Recommendation of physician for modification of school program: _____

(SPORTS PARTICIPATION CERTIFICATION FOR THE SCHOOL YEAR 20____ - 20____)

Student may participate in all interscholastic sports: Yes No

List restrictions: _____

 X _____ X _____
Physician's Signature *License Number*

 X _____ X _____
Date of Exam *Physician's Stamp*

Valley Stream Central High School District
Medical Questionnaire & Consent for Sport & Sport Physical

Name _____ School _____

Date _____ Age _____ Date of Birth _____ Grade _____

Instructions: Parent must answer questions by placing an **X** in the box provided. All "Yes" answers must be explained. All forms must be signed in the proper space. This questionnaire must be completed and signed by the parent prior to **each sport season**.

Does your child have a history of:	Yes	No	If yes, explain
1. Seizures, convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Fainting or repeated dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Severe headaches with heavy exertion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Serious head injury or repeated concussion within 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Wearing glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Loss of sight in one eye or serious eye disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Hearing loss (one or both ears)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Repeated or prolonged shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Asthma attacks?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Chronic cough or chest pain while running?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Palpitations of the heart (skipped beats)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Heart murmur or heart condition?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Have any members of your family had heart problems before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Frequent or recurrent abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Enlarged liver or spleen?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Kidney disease or absence of one kidney?	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Bloody urine or blood in bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Bleeding problems, prolonged bleeding or anemia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Hernia or rupture?	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Severe muscle or joint problem (especially knee or ankle)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. Persistent pains in any joint or in arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Limp lasting more than one week within last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Abnormality or surgery to back or spine?	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Any operation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
26. Allergy to anything specific?	<input type="checkbox"/>	<input type="checkbox"/>	_____
27. Presently taking any prescribed drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____
28. Any illness lasting over one week (such as pneumonia, mononucleosis, hepatitis, nephritis, rheumatic fever, tuberculosis, etc.)? Date Occurred _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
29. Any injuries over the past 6 months requiring medical attention?	<input type="checkbox"/>	<input type="checkbox"/>	_____
30. Being treated in hospital or emergency room over past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
31. Any reason person cannot participate in a particular sport?	<input type="checkbox"/>	<input type="checkbox"/>	_____
32. Diabetes: other chronic illness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	_____
33. Boys only: Missing one testicle?	<input type="checkbox"/>	<input type="checkbox"/>	_____
34. Girls only: Menstrual Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Date of first menstruation _____			

I have read the above questions and the answers are true to the best of my knowledge.

Please be advised that participating in an interscholastic athletic or related activity may place the student-athlete at a risk for injury. Consequent expenses, in excess of applicable insurance payments, are the sole responsibility of the student-athlete's parent/guardian.

EMERGENCY INFORMATION

Home Tel. # _____ Beeper # _____ Cell Tel. # _____

Where can parents be reached if not at home?

Mother: Address _____ Work Telephone _____

Father: Address _____ Work Telephone _____

List two neighbors or nearby relatives who will assume temporary care of your child if you can not be reached.

1. Name _____ Telephone _____ Address _____

2. Name _____ Telephone _____ Address _____

I give consent for my child (name) _____ to participate in (specific sport) _____ .
 I request that this year's sport physical remain in effect through all subsequent sport seasons for this school year. I request the school physician to perform the physical if I do not supply a private physician's report. If conditions so warrant it, I authorize the sponsor/coach/advisor to seek emergency medical help for my child.

Parent's Signature _____ Relationship to student _____