Lynbrook Public Schools

Physical/Athletic Examination Form (Only Lynbrook Public Schools Form Will Be Accepted)

If you are a Grade 7-12 Student Athlete, you MUST complete Sections 1 and 3. If you are entering Grades K,2,4,7,10, or are a new entrant, the NYS Dept of Education requires physical examinations be conducted and Sections 1 and 2 MUST be completed and be submitted to the nurse's office in your home school. NYS Department of Education recommends dental examinations for all students annually. **Make extra copies of this form!**

SECTION 1 (All Students Entering Grades K,2,4,7,10, New Entrants and All Grades 7-12 Student Athletes)

______________________ ____________ ____________________________________ ______________
Child's Last Name/First Name Date of Birth Parents'/Guardians' Name Teacher

____ ____________________ ___________
Address Phone Number Grade/ New Entrant

Ethnicity: ( ) Black (not Hispanic) ( ) White (not Hispanic) ( ) Hispanic ( ) Asian ( ) Other

Parent's Signature:____ Date: ___________________

Physician's Information (Physicians MUST also sign on the bottom of the next page for Athletic Physicals!!!!!)

___________________________ _____________________________________ ___________________
Physician's Name Physician's Address Physician's Phone Number

___________________________________ __________________
Physician's Signature **Date of Student Examination**

Examination

Does this child require any medications (please specify)? ____

Does this child have any physical challenges (specify)? ____

Is this child physically able to participate in Physical Education? If NO, list restrictions: ________________________

Are there any problems relating to growth, development or nutrition with which teacher or nurse should be acquainted? ______________

Food Allergies? ____

Height	Lungs	Nervous System	Speech
Weight	Abdomen	Thyroid	Nutrition
Blood Pressure	Hernia	Heart	Teeth/Gums
Eyes	Genitalia	Epilepsy	Posture
Ears	Skin	Orthopedic	Feet
Nose	Tonsils/Throat	Scoliosis	Range of Motion

SECTION 2-Immunizations/Preventive Measures and Tests (All Students Entering Grade K,2,4,7,10 and New Entrants)

Fill in Month/Date/Year	1st	2nd	3rd	4th	Comments
DPT – DT Td Tdap					
Polio					
MMR					
Hib/HBCV					
Hepatitis B					
Varicella					
PPD					
Meningococcal					
Measles					
Mumps					
Rubella					
Other					

Health History (Please fill in month and year below)

Allergy	Epilepsy	Operations	Serious Injury
Asthma	German Measles	Pneumonia	Tonsillectomy
Chicken Pox	Heart Condition	Polio	Tuberculosis
Diabetes	Measles	Rheumatic Fever	T.B. Contacts
Ear Condition	Mumps	Scarlet Fever	Whooping Cough

Body Mass Index (BMI): ______________________________

Weight Status Category (sex-specific BMI- for age percentile):

- _____ < 5th
- _____ 5th to < 50th
- _____ 50th to < 85th
- _____ 85th to < 95th
- _____ 95th and over

In the last twelve months, has the student had:

Prediabetes	_____Yes	_____No
Type 1 diabetes	_____Yes	_____No
Type 2 diabetes	_____Yes	_____No
Asthma	_____Yes	_____No
Prehypertension	_____Yes	_____No
Hypertension	_____Yes	_____No

SECTION 3-ATHLETIC PHYSICAL FORM (All Grades 7-12 Student Athletes)

To The Student & Guardian: Competitive athletics requires vigorous exercise and training. The District encourages all of its students to participate. To ascertain their health status, we require an annual sports-oriented evaluation. The questions below are to be completed by the guardian and the student and are to be signed by both.

THIS FORM MUST BE COMPLETED FOR ALL MIDDLE/ HIGH SCHOOL STUDENT ATHLETES AND DATED **WITHIN ONE CALENDAR YEAR OF YOUR LAST ATHLETIC PHYSICAL** BY YOUR PHYSICIAN OR THE SCHOOL PHYSICIAN. PHYSICALS ATTACHED TO THIS FORM WILL **NOT** BE ACCEPTED.

Female ________________ Male ________________ Sports (List all sports you plan to participate in) __________________________________

HAS THE STUDENT HAD ANY:

	YES	NO	
1.	______	______	Chronic/recurrent illness
2.	______	______	Illness lasting over one week
3.	______	______	Hospitalization
4.	______	______	Surgery (other than tonsillectomy)
5.	______	______	Missing organs (eye, kidney, testicle, etc)
6.	______	______	Allergy to any medications
7.	______	______	Problems with heart, blood pressure or murmur
8.	______	______	Chest pains with exercise
9.	______	______	Dizziness or fainting with exercise
10.	______	______	Dizziness, fainting, frequent headaches or convulsions
11.	______	______	Concussion or unconsciousness
12.	______	______	Heat exhaustion, heat stroke or other problems with heat

DOES THE STUDENT:

13.	______	______	Wear eyeglasses or contact lenses
14.	______	______	Wear dental bridges, braces, plates
15.	______	______	Take any medication (presently or recently)
16.	______	______	Wear any supports or braces

IS THERE A HISTORY OF:

17.	______	______	Injuries requiring MD Treatment
18.	______	______	Neck injury
19.	______	______	Knee injury or ankle injury
20.	______	______	Other serious joint injury
21.	______	______	Broken bones
22.	______	______	Is there any reason this student should not participate in athletics
23.	______	______	Has any family member, younger that 40 years of age, died suddenly due to an incident other than an accident
24.	______	______	Has any family member had a heart attack younger than 55 years of age

Explain any "Yes" response and provide additional information, if necessary:

____

____

Date of Last Tetanus Shot: ______________

We understand the statements above to be true and consent is hereby given that __________________ **may participate in interscholastic athletics.**

Students Signature ______________________________ **Date** _______ **Parents Signature** _____________________________ **Date** ___________

This Section to be complete by Physician

Review of Questionnaire __________________ **Positive Findings** ____

1. Collision Contact ________________ **2. Limited Contact** _______________________ **3. Non-Contact** ____________________________

Based on this history and exam, the following abnormalities were found and need attention and treatment:

____

Recommendations:

1. _________There is no history or physical finding which would prohibit this student from participating in athletics.
2. _________This student should have the following health problems evaluated and/or treated before participating in athletics:

____

3. _________This student has health problems which prohibits him/her from participation in athletics.

Signature of Physician ________________________________ **Date of Examination** _________________________________