DEPARTMENT OF HEALTH * THE CITY OF NEW YORK * DEPARTMENT OF EDUCATION

INTERSCHOLASTIC * SPORTS EXAMINATION * – CONFIDENTIAL

STUDENT

PART 1 to be filed in Student's Health folder

OSIS# — — — — — — — I.D.# — — — — — — —

NAME: ____________ SCHOOL: ____________ BOROUGH: ____________

ADDRESS: ____________ HOMEROOM: ____________ GRADE: ____________

____

____________ DATE OF BIRTH: ____________

TELEPHONE: ____________ EMERGENCY TELEPHONE: ____________

SPORT: ____________

SPORT: ____________

PARENT 2

PARENTAL PERMISSION: I have reviewed the STUDENTS MEDICAL HISTORY section below and I agree with the answers. I give permission for ____________ to have a physical examination. I understand that completion of the Maturation Index is optional.

SIGNATURE ____________

DATE: ____________ RELATIONSHIP ____________

* *

CLINICIAN'S RECOMMENDATIONS

Based on my review of the history and physical examination as noted below and on the back of this form, and review of the guidelines on P. 4, this student:

(1) May participate in the following sports:
DRAW A LINE THROUGH ANY SPORTS TO BE OMITTED:

CONTACT	ENDURANCE	OTHER
Football	Gymnastics	Bowling
Baseball	Swimming	Golf
Basketball	Track & Field	Archery
Soccer	Cross-country	Field Events
Hockey	Tennis	Cheerleading
Wrestling	Volleyball	
Lacrosse	Handball	DATE OF LAST TETANUS BOOSTER: ____________
Softball	Fencing	

(2) Special conditions for participation (e.g., pre-exercise medication or protective equipment), if any:

DATE ____________ SIGNATURE: ____________ (CLINICIAN)

TELEPHONE: ____________ NAME: (PRINT) ____________

ADDRESS: ____________

REGISTRY # ____________ ____________

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STUDENT'S MEDICAL HISTORY

(To be filled out by student and parent) Clinician's Comments

DOCTOR FILLS OUT COMPLETELY THEN SIGNS + STAMPS FORM

Has anyone in your family under age 45 died suddenly?	Yes ☐	No ☐
Have you ever had:		
Concussion or been knocked out?	Yes ☐	No ☐
Fainting?	Yes ☐	No ☐
Heat Stroke?	Yes ☐	No ☐
Epilepsy, seizures, or fits?	Yes ☐	No ☐
Head or neck injury?	Yes ☐	No ☐
Very bad vision in one or both eyes?	Yes ☐	No ☐
Do you wear glasses, contacts, other?	Yes ☐	No ☐
Have you ever had:		
Hearing loss or deafness?	Yes ☐	No ☐

(OVER)

STUDENT'S MEDICAL HISTORY — CONTINUED:

(To be filled out by student and parent)

Clinician's Comments

Perforated ear drum or "tubes" in ears?	Yes ☐	No ☐
Draining ears?	Yes ☐	No ☐
Have you ever had:		
Sinus problems or hay fever	Yes ☐	No ☐
Braces or removable false teeth	Yes ☐	No ☐
Have you ever had:		
Any broken bones? _____	Yes ☐	No ☐
Dislocation or other serious problem?	Yes ☐	No ☐
Serious foot problem?	Yes ☐	No ☐
Back injury or frequent backaches?	Yes ☐	No ☐
Ankle or knee injury or problem?	Yes ☐	No ☐
Other joint problems?	Yes ☐	No ☐
Do you have a hernia?	Yes ☐	No ☐
Boys: Any problems with testicles?	Yes ☐	No ☐
Girls: Any menstrual problem?	Yes ☐	No ☐
Age at first menstrual period? _____		
Do you miss school because of your period?	Yes ☐	No ☐
Have you ever had:		
Diabetes?	Yes ☐	No ☐
Single illness for more than 10 days?	Yes ☐	No ☐
Any operations?	Yes ☐	No ☐
Easy bruising or bleeding tendency?	Yes ☐	No ☐
Anemia	Yes ☐	No ☐
Asthma?	Yes ☐	No ☐
Bee sting allergy?	Yes ☐	No ☐
Other allergies (food or medicine)	Yes ☐	No ☐
Heart trouble or murmurs?	Yes ☐	No ☐
High blood pressure?	Yes ☐	No ☐
Cough lasting more than 3 weeks?	Yes ☐	No ☐
Chest pain or faintness with exercise?	Yes ☐	No ☐
Kidney problems?	Yes ☐	No ☐
Skin infections?	Yes ☐	No ☐
Do you take any medicines?	Yes ☐	No ☐
Do you smoke?	Yes ☐	No ☐
Have you ever been told not to play any sport because of your health?	Yes ☐	No ☐

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PHYSICAL EXAMINATION

A complete physical examination for all students is recommended. Omission of the Maturation Index will not disqualify a student from participation.

DOCTOR

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision Uncorrecred: L 20/ _____ R 20/ _____ Corrected: L 20/_____ R 20/ _____

	Normal	Abnormal	Comments
Skin			
Eyes			
ENT			
Mouth & Teeth			
Neck			
Cardiovascular			
Lungs, Chest			
Spine			
Abdomen			
Genitalia (Hernia)			
Maturation Index _____			
Extremities			
Orthopedic			
Neuromuscular			

Other tests, if done (Lab, ECC, etc.):

Assessment:

Plan: