# SEWANHAKA CENTRAL HIGH SCHOOL DISTRICT

## HEALTH HISTORY FORM

## TO BE COMPLETED BY PARENT OR GUARDIAN PRIOR TO PHYSICAL EXAMINATION

**NOTE: Any physical taken JUNE 1ST OR THEREAFTER is valid through JUNE 30TH of the following year.**

**(Please Print)**

Student Name:_____ _____ _____

Last Name First Name School Year of Graduation

Home Address:_____ Home #: _____

Street City State Zip Code Work/Cell #: _____

Date of Birth:_____ Age:_____ Sex: [ ] Male [ ] Female

**Please circle appropriate sport that your child intends to play during the present school year, and check designated level:**

| FALL | Level V | JV | JH | WINTER | Level V | JV | JH | SPRING | Level V | JV | JH |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cheerleading | __ | __ | __ | Basketball | __ | __ | __ | Badminton (F) | __ | NA | NA |
| Cross Country | __ | NA | __ | Bowling | __ | __ | NA | Baseball | __ | __ | __ |
| Football | __ | __ | __ | Gymnastics | __ | NA | __ | Golf (F) | __ | NA | NA |
| Golf (M) | __ | NA | NA | Riflery | __ | NA | NA | Lacrosse | __ | __ | __ |
| Soccer | __ | __ | __ | Track | __ | NA | __ | Softball | __ | __ | __ |
| Field Hockey | __ | __ | __ | Wrestling | __ | __ | __ | Track | __ | NA | __ |
| Tennis (F) | __ | NA | NA | Volleyball | __ | __ | __ | Tennis (M)) | __ | NA | NA |
| Volleyball | __ | __ | __ | | | | | | | | |
| *Other_____ | __ | __ | __ | *Other_____ | __ | __ | __ | *Other_____ | __ | __ | __ |

***Please Specify V=Varsity; JV= Junior Varsity; JH=Junior High; NA (Not Available)**

**I prefer that my child be examined by: [ ] School Physician [ ] Private Physician**

**HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS? (Please check YES or NO for each question)**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| [ ] | [ ] | 1. Chronic or recurrent illness? | [ ] | [ ] | 17. Date of Last Dental Exam_____. |
| [ ] | [ ] | 2. History of seizures? | [ ] | [ ] | 18. Diagnosed with scoliosis? |
| [ ] | [ ] | 3. Bleeding disease or anemia? | [ ] | [ ] | 19. Wears dental bridges, braces, plates? |
| [ ] | [ ] | 4. Diabetes? | [ ] | [ ] | 20. Wears eyeglasses or contact lenses? |
| [ ] | [ ] | 5. Absence or loss of function of one organ (ovary, testicle, eye, kidney)? Specify _____ | [ ] | [ ] | 21. Injury requiring medical treatment or evaluation? |
| | | | [ ] | [ ] | 22. *Have any **immediate family members** had a heart attack or heart trouble under the age of 50? |
| [ ] | [ ] | 6. Does student take any medication? | | | |
| [ ] | [ ] | 7. Hearing impairment? | [ ] | [ ] | 23. Dizziness or fainting, frequent headaches, or convulsions? |
| [ ] | [ ] | 8. Lung or respiratory problems (asthma)? | [ ] | [ ] | 24. Concussion or unconsciousness within the past 12 months? |
| [ ] | [ ] | 9. Heart murmur? Any congenital heart defect or recent inflammation of the heart? | [ ] | [ ] | 25. Heat exhaustion, heatstroke, or other problems with heat? |
| | | | [ ] | [ ] | 26. Lose weight regularly to improve performance in sports? |
| [ ] | [ ] | 10. Hospitalizations? | [ ] | [ ] | 27. Any unexplained weight loss or weight gain during the past six months? |
| [ ] | [ ] | 11. Previous heart problems or heart surgery? | | | |
| [ ] | [ ] | 12. High blood pressure? | [ ] | [ ] | 28. Currently following any particular diet or weight reducing plan? |
| [ ] | [ ] | 13. Any known allergies or allergy to medication? | | | |
| [ ] | [ ] | 14. Illness lasting over (5) days? | [ ] | [ ] | 29. History of eating disorders? |
| [ ] | [ ] | 15. Operations? Date(s) Specify:_____ | [ ] | [ ] | 30. Age of first menstrual period (for females) _____. |
| [ ] | [ ] | 16. Chest pain with exercise? | [ ] | [ ] | 31. I grant permission for my child to carry and use an FDA Approved over the counter sunscreen at school. |

If you answer **YES** to any questions, you may be required to present a note from your physician for clearance.

Use this space to **EXPLAIN** any of the above numbered YES answers or to provide any additional information:

_____

_____

***#22 LIST** Family Members & Explain Condition:_____

_____

_____

Parent or Guardian Signature Date

**NOTE: NY State law requires that students must submit a completed Health Examination form within 30 days after first entering school, and upon entry to 7th and 10th grades.**

***Revised Jul. 26, 17***

# HEALTH EXAMINATION

| Last Name First Name | Birth Date | Sex | School | Year of Graduation |
|---|---|---|---|---|
| | | | | |

## TO BE COMPLETED BY PHYSICIAN:

**Date of examination:**_____

**Allergies:**_____ **Medications:**_____

**Screens:**

Vision [ ] Without eyeglasses [ ] With eyeglasses *R_____ *L_____

Hearing Test (Sweepcheck) *R_____ *L_____

**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

Last Cholesterol Level_____

**Exam:** Height_____ Weight_____ Pulse_____ BP_____

| | √ = Normal | Abnormal – Explain |
|---|---|---|
| Skin | | |
| Eyes | | |
| ENT | | |
| Lymph nodes/Thyroid | | |
| Teeth and gums | | |
| Heart | | |
| Chest and lungs | | |
| Abdomen | | |
| Genitalia/hernia | | |
| Tanner Stage | I. II. III. IV. V. | |
| Scoliosis Screen | | |
| Musculoskeletal/Orthopedic | | |
| Neurological/Cognitive | | |

Immunization given today: 1)_____ 2)_____ 3)_____

Tdap: 1)_____ Varicella: 1)_____ 2)_____ Menactra: 1)_____ 2) _____

**Assessment (please circle)**

a) This student may participate in all school activities and sports

b) This student should have the following health problem evaluated or treated before participation:

_____

c) Protective equipment required: ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other_____

d) Put a line through activities not permitted:

| ***Contact/Collision*** | ***Limited Contact*** | ***Non-contact*** | ***Other Recommendations*** |
|---|---|---|---|
| Football, (B) Lacrosse, Wrestling | Baseball, Badminton, Basketball, Field Hockey, (G) Lacrosse, Soccer, Softball Volleyball, Gymnastics, Cheerleading | Bowling, Cross-country, Golf Swimming, Tennis, Track and Field | |

***Please note: This is a two sided form and both sides must be completed prior to approval.**

## School District Sports Approval

**Approved** **Disapproved**

Pending:_____

_____
***Health Care Provider Signature & Stamp**

MD Signature & Date_____