

CHRISTIAN BROTHERS ACADEMY

HEALTH OFFICE PHONE:

452-9809, EXT. 128

FAX: 452-9804

SCHOOL HEALTH EXAMINATION

Student Name: _____ Date of Birth: _____ Grade: _____ School yr _____
Address: _____

PHYSICAL EXAM

Height: _____ Weight: _____ BMI _____
BP _____/_____ (sitting/standing/lying down, right arm /left arm)
Eyes: R _____ L _____ Visual acuity: L _____ R _____
Ears: (Otoscope) R _____ L _____
Audiogram: R _____ L _____
Lymph Nodes: _____
Thyroid: _____
Nose: _____
Tonsils: _____
Teeth: _____
Heart: _____
Lungs: _____
Hernia: _____
Genito-Urinary _____
Tanner: _____

State legislation mandates scoliosis screening for each child between the ages of 8 and 16 years

Screening negative Screening positive
Follow-up _____
Skin: _____
Nutrition: _____
Speech: _____
Other: _____

Please complete the above information for students who plan to participate in interscholastic sports. Thank-you.

Resting pulse: _____ Rate post exercise _____
Post 2 min. rest: _____
Urinalysis: _____
Protein: _____ Sugar: _____

Office stamp below please:

IMMUNIZATION RECORD

DtaP or specify _____ /_____/_____
_____/_____/_____, _____ /_____/_____
_____/_____/_____, _____ /_____/_____
Polio _____ /_____/_____, _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
HIB _____ /_____/_____, _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
MMR _____ /_____/_____, _____ /_____/_____
Hepatitis B _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
Varivax _____ /_____/_____, _____ /_____/_____ Varicella Illness _____ /_____/_____
Menactra _____ /_____/_____, Other _____ /_____/_____
Gardasil _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
Or attach Immunization Record _____

HEALTH HISTORY

Allergies: _____
Asthma: _____
Chronic Conditions: _____
Physical Limitations: _____
Any restrictions to full participation in physical education?

For secondary students (grades 7-12): Please check if qualified for Interscholastic sports:

- Contact/Collision Limited Contact/Impact
- Strenuous Non-Contact Non-strenuous Non-contact

I HAVE COMPLETED THE ABOVE PHYSICAL AND FIND THAT THIS STUDENT IS QUALIFIED TO PARTICIPATE IN ALL THE CHECKED CATEGORIES OF COMPETITION DURING THE SCHOOL YEAR.

Signed: _____
Medical Examiner, Title

Date of Exam _____ /_____/_____

FOR SCHOOL USE ONLY: INTERVAL HISTORY COMPLETED BY SCHOOL NURSE.

Fall: _____ /_____/_____
Sport _____ Winter: _____ /_____/_____
Sport _____ Spring: _____ /_____/_____
Sport _____

(student's name)

Explain "Yes" answers below. If you are uncertain about how to answer any questions, please mark "Don't Know" and the physician will discuss it with you.

"Don't Know"

- | | | | |
|--|-----|----|-------|
| 1. Have you ever been hospitalized or had surgery? | Yes | No | _____ |
| 2. Have you had a medical problem or injury in the past two years? | Yes | No | _____ |
| 3. Are you taking any prescription or non-prescription medications, including inhalers? | Yes | No | _____ |
| 4. Do you have any allergies to foods, medications or bees? | Yes | No | _____ |
| 5. Have you ever become dizzy or passed out during or after exercise? | Yes | No | _____ |
| 6. Do you tire more quickly than your friends during exercise? | Yes | No | _____ |
| 7. Have you ever had chest pain during or after exercise? | Yes | No | _____ |
| 8. Have you ever been told that you have a heart murmur or heart disease? | Yes | No | _____ |
| 9. Have you had racing of your heart or skipped heartbeats? | Yes | No | _____ |
| 10. Has anyone in your family had a heart attack, heart disease or sudden death before age 50? | Yes | No | _____ |
| 11. Has a physician ever denied or restricted your participation in sports for any reason? | Yes | No | _____ |
| 12. Do you have any skin problems (itching, rashes, acne, eczema, warts, fungus, blisters)? | Yes | No | _____ |
| 13. Have you ever had a rash or hives develop during or after exercise? | Yes | No | _____ |
| 14. Have you ever been knocked out, lost your memory, or become unconscious? | Yes | No | _____ |
| 15. Have you ever had a seizure or epilepsy? | Yes | No | _____ |
| 16. Have you ever had a stinger, burner, pinched nerve or pain from neck to arm? | Yes | No | _____ |
| 17. Do you have frequent or severe headaches? | Yes | No | _____ |
| 18. Have you ever had heat or muscle cramps, heat exhaustion or heat stroke? | Yes | No | _____ |
| 19. Have you ever been dizzy or passed out in the heat? | Yes | No | _____ |
| 20. Do you have trouble breathing or do you cough or wheeze during or after exercise? | Yes | No | _____ |
| 21. Do you have asthma? | Yes | No | _____ |
| 22. Do you use any special equipment (braces, orthotics, mouth guard, retainer, eye guards)? | Yes | No | _____ |
| 23. Do you have capped teeth, bridges, or partial dentures? | Yes | No | _____ |
| 24. Have you ever had any trouble with your eyes or vision? | Yes | No | _____ |
| 25. Do you wear contacts or glasses? | Yes | No | _____ |
| 26. Do you have any ear disease, hearing problems or do you wear hearing aids? | Yes | No | _____ |
| 27. Have you ever sprained/strained, dislocated, fractured, broken any bones or joints? | Yes | No | _____ |
| 28. Have you had other medical problems (mono, diabetes, myocarditis, hepatitis, cancer, etc.) | Yes | No | _____ |
| 29. Does anyone in your family have Marfan's syndrome? | Yes | No | _____ |
| 30. Have you ever been diagnosed with blood or bleeding disorders? | Yes | No | _____ |
| 31. Have you experienced abdominal discomfort, constipation, diarrhea on a frequent basis? | Yes | No | _____ |
| 32. Are you comfortable with your body weight? | Yes | No | _____ |
| 33. Do you diet frequently or are you dieting now? | Yes | No | _____ |
| 34. Have you ever tried to control weight by vomiting, using laxatives, diuretics or diet pills? | Yes | No | _____ |
| 35. Have you ever taken supplements, medications or vitamins to improve your performance? | Yes | No | _____ |
| 36. Do you have only one kidney? | Yes | No | _____ |
| 37. For Boys: Do you have only one testicle? | Yes | No | _____ |
| 38. For Girls: Are your menstrual periods regular? | Yes | No | _____ |
| a. Date of first menstrual period? _____ Date of last menstrual period? _____ | | | |
| b. What was the longest time between your periods last year? _____ | | | |

Explain any "yes" answers here:

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.		
I give my permission for _____ to participate in ANY sport offered by South Colonie Schools.		
I DO NOT give my permission for _____ to participate in the following sport/sports: _____		
Signature of Parent/Guardian: _____	Date: _____	Signature of Athlete: _____