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 Entry into 9th Grade:_____

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	
1.	[ ]	[ ]	Chronic or recurrent illness?
2.	[ ]	[ ]	Bleeding disease or anemia?
3.	[ ]	[ ]	Diabetes?
4.	[ ]	[ ]	Absence or loss of function of one organ (ovary, testicle, eye, kidney)? Specify _____
5.	[ ]	[ ]	Does student take any medication?
6.	[ ]	[ ]	Hearing impairment?
7.	[ ]	[ ]	Lung or respiratory problems (asthma)?
8.	[ ]	[ ]	Heart murmur? Any congenital heart defect or recent inflammation of the heart?
9.	[ ]	[ ]	Hospitalizations?
10.	[ ]	[ ]	Previous heart problems or heart surgery?
11.	[ ]	[ ]	High blood pressure?
12.	[ ]	[ ]	Any known allergies or allergy to medication?
13.	[ ]	[ ]	Illness lasting over (5) days?
14.	[ ]	[ ]	Operations? Date(s) Specify:_____
15.	[ ]	[ ]	Chest pain with exercise?
16.	[ ]	[ ]	Diagnosed with scoliosis?
17.	[ ]	[ ]	Wears dental bridges, braces, plates?
18.	[ ]	[ ]	Wears eyeglasses or contact lenses?
19.	[ ]	[ ]	Injury requiring medical treatment or evaluation?
20.	[ ]	[ ]	*Have any **immediate family members** had a heart attack or heart trouble under the age of 50?
21.	[ ]	[ ]	Dizziness or fainting, frequent headaches, or convulsions?
22.	[ ]	[ ]	Concussion or unconsciousness?
23.	[ ]	[ ]	Heat exhaustion, heatstroke, or other problems with heat?
24.	[ ]	[ ]	Lose weight regularly to improve performance in sports?
25.	[ ]	[ ]	Any unexplained weight loss or weight gain during the past six months?
26.	[ ]	[ ]	Currently following any particular diet or weight reducing plan?
27.	[ ]	[ ]	History of eating disorders?
28.	[ ]	[ ]	Age of first menstrual period (for females) _____.
29.	[ ]	[ ]	History of seizures
30.	[ ]	[ ]	I would like my child to have a **cholesterol screening.**

Date of Last Dental Examination_____

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:

_____

_____

_____

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

_____

_____ _____

Student Signature Parent or Guardian Signature Date

NOTE: As of NY State requirement, all 7th and 10th grade students must complete a Health Examination form and it must be submitted prior to OCTOBER 1st to the health office.

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)_____

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.**

☐ **Approved** **Disapproved** ☐

_____

***Health Care Provider Signature**

Stamp:

Telephone No:_____

For District Use:
Disqualified
Call: Date:_____

Letter: Date:_____

Note: *Must be reviewed for final approval by school physician