CORNING-PAINTED POST
AREA SCHOOL DISTRICT

Students are the center of all we do.

Annual or Athletic Competition Health Screening Form

Name ____________________ Sport __________ School __________ Grade ______

Date ______________ Date of Birth ____________________ H.R. ______

This side of the form MUST be completed by the parent/guardian on or before the time of the physical to qualify for an athletic sport.

HAS YOUR CHILD EVER:	YES	NO
been restricted in gym or sports participation for medical reasons?	____	____
been unconscious or lost memory from a blow on the head (concussion)?	____	____
Felt fain, dizzy, had chest pain or a fainting spell during exercise?	____	____

HAS YOUR CHILD EVER HAD:	YES	NO
convulsions/seizures	____	____
fainitng spells	____	____
diabetes	____	____
rheumatic fever	____	____
arthritis	____	____
nosebleeds (frequent/severe)	____	____
elevated blood pressure	____	____

HAS YOUR CHILD EVER HAD:	YES	NO
heart problems	____	____
injury to spleen	____	____
neck or back injury	____	____
bladder/kidney problem	____	____
asthma related to exercise	____	____
allergies/hay fever	____	____
bee sting allergy	____	____
Sickle cell trait	____	____

Explain: ____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING :	YES	NO
one eye or severe, uncorrectable loss of vision in one or both eyes?	____	____
severe hearing loss in one or both ears?	____	____
a single kidney or a single testicle?	____	____
special orthodontic appliances or capped teeth?	____	____
glasses or contact lenses for sports?	____	____
physical handicap either from birth, illness, or injury?	____	____

Explain: ____

HAS YOUR CHILD IN THE PAST YEAR HAD :	YES	NO
headaches?	____	____
ear problems/hearing loss?	____	____
ankle injury?	____	____
joint sprain/ligament tear/muscle pull?	____	____
fracture or dislocation of any bone or joint?	____	____
anemia?	____	____
eye problem/vision loss?	____	____
knee injury?	____	____
any remaining problems with a previous injury? Any continuing treatment?	____	____
any illness, condition, injury requiring activity/limitations, absences over 5 days?	____	____
is your child under medical care now? Taking any medications now? If so, explain:	____	____

Has there ever been a sudden cardiac death of a family member under age 50? **Y or N** If yes, explain: ____________________

I understand that participation in athletics is voluntary. The above answers are accurate. I agree to the participation of my student in an athletic program of his/her school including practice sessions and travel to and from athletic contests.

Parent signature: ____________________________ Date: __________

***Please print form double sided**

Health Appraisal Form

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7, and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

Name ______________________ Date of Physical Exam __________

School __________ Gender M F Grade ______ DOB __________

IMMUNIZATIONS/HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal

Sickle Cell Screen: ☐ Pos ☐ Neg ☐ Not Done Date ________
PPD: ☐ Pos ☐ Neg ☐ Not Done Date ________
Elevated Lead: ☐ Yes ☐ No ☐ Not Done Date ________
Dental Referral: ☐ Yes ☐ No ☐ Not Done Date ________

Significant Medical/ Surgical History: ☐ see attached ______________________

Specify current diseases:
☐ Asthma
☐ Diabetes ☐ Type 1 ☐ Type 2
☐ Hyperlipidemia
☐ Hypertension
☐ Other ______________________

Allergies:
☐ LIFE THREATENING
☐ Seasonal ______________________
☐ Insect ______________________
☐ Food ______________________
☐ Other ______________________
☐ Medication ______________________

PHYSICAL EXAM

Height __________ Weight __________ Blood Pressure __________ Date of Screenings __________

BMI __________
Weight Status Category (BMI percentile):
☐ less than 5th ☐ 5th - 49th ☐ 50th - 84th
☐ 85th - 94th ☐ 95th - 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing Pass 20db sc both ears or	R	L	

☐ **Exam Entirely Normal** Tanner: I. II. III. IV. V. Scoliosis: ☐ Neg. ☐ Pos.: ________
specify any adnormality: ______________________

MEDICATIONS

Medications (list all) ☐ None ☐ Additional medications listed on reverse of this form
Name: ______________________ Dosage/Time ______________________
Name: ______________________ Dosage/Time ______________________
If AM dose is missed at home: ______________________
☐ Physician's Order for Giving Medication in School form attached

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities**.
☐ Limited Contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
☐ Non-Contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
☐ Specify medical accommodations needed for school: ______________________ ☐ None
☐ Known or suspected disability: ______________________
☐ Restrictions: ______________________
☐ Protective equipment required: ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other ________

Provider's Signature: ______________________ Phone: ______________
Provider's Name/Address: ______________________ Fax: ______________
______________________ Other: ______________

(stamp below)

This exam complies with the NYSED requirements above and is vallid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

***Please print form double sided**