# WANTAGH PUBLIC SCHOOL

## *PHYSICAL EXAM / INTERSCHOLASTIC SPORTS EXAM*

To be completed for all new students and enrolled students in grades 7th, 10th, & yearly for Interscholastic Sports participation.

**NAME**_____**GRADE**_____**DATE of BIRTH**_____

**SPORT**_____**TELEPHONE**_____

### IMMUNIZATIONS & DISEASE UPDATE

| | | Dates | | | | | Dates | | |
|---|---|---|---|---|---|---|---|---|---|
| Polio (OPV/IPV) | | | | | DTP | | | | |
| Measles | | | | | Tdap | | | | |
| Mumps | | | | | Td | | | | |
| Rubella | | | | | Tetanus | | | | |
| MMR | | | | | HepB | | | | |
| HIB | | | | | Varicella | | | | |
| Other | | | | | | | | | |

**For Interscholastic Competitive Athletic Activities Only** (questions 1-12 to be completed by **parent/student**; date and describe)

1. Have you ever had any fractures, dislocations, severe sprains or serious injuries? ❑ No ❑ Yes_____
2. Have you ever been hospitalized? ❑ No ❑ Yes_____
3. Have you ever had surgery? ❑ No ❑ Yes_____
4. Do you have any allergies? ❑ No ❑ Yes Seasonal ❑ No ❑ Yes Other (list):_____
5. Do you take any medication now? ❑ No ❑ Yes If "Yes" what:_____
6. Have you ever been refused permission to participate in athletics? ❑ No ❑ Yes_____
7. Do you wear glasses or contact lenses? ❑ No ❑ Yes
8. Have you ever had a concussion? ❑ No ❑ Yes If "Yes" how many:_____ when:_____
9. Has there ever been a sudden death in your family? ❑ No ❑ Yes If "Yes" who:_____
10. Have you ever passed out or lost consciousness during physical activity? ❑ No ❑ Yes If "Yes" when:_____ where: _____
11. Do you currently or plan to use over the counter diet/nutritional supplements (i.e.: ephedra, creatine, etc)? ❑ No ❑ Yes If "Yes" which one(s):_____
12. Do you have Heart Disease, Diabetes, Asthma, Angina or a Neurologic Condition? ❑ No ❑ Yes If "Yes" which one(s):_____

*School Nurse's comments*_____

### MEDICAL EXAMINATION *(to be completed by Physician)*

*Height _____*Weight_____ Skin_____ Heart_____
*BMI_____*BMI percentile_____ Head_____ Abdomen_____
*Blood Pressure:_____Pulse_____ Eyes_____ Genito-Urinary _____
Urine: sugar_____ protein_____ Ears_____ Hernia_____
Date of onset of menses:_____ Nose & Throat_____ Nutrition_____
Date of last menstrual period:_____ Chest_____ *Scoliosis: neg_____pos_____

***ACTUAL READINGS REQUIRED***

This certifies that the above named student is physically qualified to participate in the following categories of competition. *(to be completed by physician)*

| COLLISION | CONTACT | | STRENUOUS | NON-CONTACT | NON-STRENUOUS |
|---|---|---|---|---|---|
| ❑ Yes ❑No | ❑ Yes ❑ No | | ❑ Yes ❑ No | ❑Yes ❑ No | ❑ Yes ❑ No |
| Football | Baseball | Basketball | Dance Team | Badminton | Bowling |
| Lacrosse (Boys) | Lacrosse (Girls) | Volleyball | Swimming | Softball | Golf |
| Wrestling | Cheerleading | Gymnastics | Cross Country | | |
| Soccer | | | Tennis | | |
| | | | Track & Field | | |

❑All Sports

Reason for Disqualification _____

Date of Physical_____ Physician's Signature_____

HS-17E 2/08 Physician's Stamp_____

Date of Physical_____ Physician's Signature_____

HS-17E 2/08 Physician's Stamp_____