DEPARTMENT OF HEALTH * THE CITY OF NEW YORK * BOARD OF EDUCATION
INTERSCHOLASTIC * SPORTS EXAMINATION * - CONFIDENTIAL

SHADED SECTION MUST BE COMPLETED BY THE PARENT/GUARDIAN

OSIS # ____ ____ ____ - ____ ____ ____ - ____ ____ ____ **ID #** ____ ____ ____ ____

NAME: ______________________________ **SCHOOL:** ______________ **BOROUGH:** ________

ADDRESS: ______________________________ **HOMEROOM:** ______________ **GRADE:** ______

____

DATE OF BIRTH: ______________________________ **TELEPHONE #:** (_______) ____________________

EMERGENCY PHONE #: (_______) ____________________ **CELL PHONE #:** (_______) ____________________

SPORT: ______________________________ **SPORT:** ______________________________

PARENTAL PERMISSION: I have reviewed the STUDENTS MEDIAL HISTORY section below and I agree with the answers. I give permission for ______________________________ to have a physical examination.

SIGNATURE: ______________________________ **DATE:** ______________________________

RELATIONSHIP: ______________________________

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

CLINCIAN'S RECOMMENDATIONS

Based on my review of the history and physical examination as noted below and on the back of the form, and review of the guidelines regarding athletic participation, this student:

May participate in the following sports:
DRAW A LINE THROUGH ANY SPORTS TO BE OMITTED:

CONTACT	**ENDURANCE**	**OTHER**
Football	Gymnastics	Bowling
Baseball	Swimming	Gold
Basketball	Track & Field	Archery
Soccer	Cross-Country	Field Events
Hockey	Tennis	Cheerleading
Wrestling	Volleyball	
Lacrosse	Handball	DATE OF LAST TETANUS BOOSTER: _________

Special conditions for participation (e.g. pre-exercise mediation or protective equipment), if any:

DATE: ______________________________ SIGNATURE: ______________________________

TELEPHONE #: (_______) ____________________ NAME (PRINT): ______________________________

ADDRESS: ______________________________

REGISTRY #: ______________________________ ______________________________

TO BE COMPLETED BY STUDENT AND PARENT/GUARDIAN:

Has anyone in your family under age
Died suddenly? Yes☐ No☐

Have you ever had:
- Concussion or been knocked out? Yes☐ No☐
- Fainting? Yes☐ No☐
- Heat Stroke? Yes☐ No☐
- Epilepsy, seizures, or fits? Yes☐ No☐
- Head or neck injury? Yes☐ No☐
- Very bad vision in one or both eyes? Yes☐ No☐
- Do you wear glasses, contacts, other? Yes☐ No☐

CLINICIAN'S COMMENTS:

____

TO BE COMPLETED BY STUDENT AND PARENT/GUARDIAN | **CLINICIAN'S COMMENTS**:

Question	Yes	No	Clinician's comments
Perforated ear drum or "tubes" in ears?	Yes☐	No☐	________
Draining ears?	Yes☐	No☐	________
Have you ever had:			
Sinus problems or hay fever?	Yes☐	No☐	________
Braces or removable false teeth?	Yes☐	No☐	________
Have you ever had:			
Any broken bones?	Yes☐	No☐	________
Dislocation or other serious problems?	Yes☐	No☐	________
Serious foot problems?	Yes☐	No☐	________
Back injury or frequent backaches?	Yes☐	No☐	________
Ankle or knee injury or problem?	Yes☐	No☐	________
Other joint problems?	Yes☐	No☐	________
Do you have a hernia?	Yes☐	No☐	________
Boys: Any problems with testicles?	Yes☐	No☐	________
Girls: Any menstrual problems?	Yes☐	No☐	________
Age at first menstrual period?________			
Do you miss school because of your period?	Yes☐	No☐	________
Have you ever had:			
Diabetes?	Yes☐	No☐	________
Single illness for more than 10 days?	Yes☐	No☐	________
Any operations?	Yes☐	No☐	________
Easy bruising or bleeding tendency?	Yes☐	No☐	________
Anemia?	Yes☐	No☐	________
Asthma?	Yes☐	No☐	________
Bee sting allergy?	Yes☐	No☐	________
Other allergies (food or medication)	Yes☐	No☐	________
Heart trouble or murmurs?	Yes☐	No☐	________
High blood pressure?	Yes☐	No☐	________
Cough lasting more than 3 weeks?	Yes☐	No☐	________
Chest pain or faintness with exercise?	Yes☐	No☐	________
Cough lasting more than 3 weeks?	Yes☐	No☐	________
Chest pain or faintness with exercise?	Yes☐	No☐	________
Kidney problems?	Yes☐	No☐	________
Skin infection?	Yes☐	No☐	________
Do you take any medicines?	Yes☐	No☐	________
Do you smoke?	Yes☐	No☐	________
Have you ever been told not to play any sport Because of your health?	Yes☐	No☐	________

PHYSICAL EXAMINATION

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

HEIGHT: ____________ WEIGHT: ____________ PULSE: ______________ BLOOD PRESSURE: __________________

VISION UNCORRETED: L20/ _________ R20/ _________ CORRECTED: L20/________ R20/_________

	NORMAL	**ABNORMAL**	**COMMENTS**
Skin	☐	☐	________
Eyes	☐	☐	________
ENT	☐	☐	________
Mouth & Teeth	☐	☐	________
Cardiovascular	☐	☐	________
Lungs, Chest	☐	☐	________
Spine	☐	☐	________
Abdomen	☐	☐	________
Genitalia (Hernia)	☐	☐	________
Tanner Stage	☐	☐	________
Extremities			
Orthopedic	☐	☐	________
Neuromuscular	☐	☐	________

Assessments: __ **Plan:**

____

(CLINICIAN'S SIGNATURE)

STAMP & SIGN