NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT PHYSICAL EXAM FORM
SCHOOL_____

Name: _____ □ M □ F Date of Birth: _____ Grade_____

Immunizations & Screening

**Required for NYS school entry, varies by age and grade*

□ None given today □ Given since last exam □ Record attached

	1st	2nd	3rd	4th	5th
DtaP	*	*	*	*	*
Polio □IPV □OPV	*	*	*		
HIB					
Tdap		**Tetanus**	**(Td)**		
Hepatitis B	*	*	*		
MMR	*	*			
Varivax	*		□ Disease ___/__/__		
Pneumococcal	*	*	*	*	

*4 IPV only

Screening Must Be Completed

Vision: Distance ☐ Unaided	R	L
Vision: Distance □ glasses □ contact lenses	R	L
Vision: Near Point ☐ Unaided	R	L
Vision: Near Point □ glasses □ contact lenses	R	L
Hearing: □Pass 20dB both ears or as indicated □ Screening □ Audiogram	R	L

Medical History

1) Significant medical/surgical history:_____
2) Allergies: _____
3) Medications taken: ☐ No ☐ Yes List: _____

If medication *is required for school and/or sports, a **SCHOOL MEDICATION AUTHORIZATION form must be on file in the school health office**

Physical Examination

Date of Exam____ /____/____

Height: _____ Weight: _____ BP: _____/_____ Resting Pulse: _____ Fe LMP: _____

	Normal	Abnormal
General Appearance		
Nutrition		
Skin		
Head		
Eyes		
Ears		
Nose/Throat		
Teeth		
Neck: Nodes/Thyroid		
Lungs		
Heart/Murmur		
Pulses		
Abdomen		
Genitalia		
Neurological		
Musculoskeletal		
Scoliosis	□ Negative	□ Positive

COMPLETE PER NYSED LAW, SECTION 903

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

*Tanner Stage: □ I. □ II. □ III. □ IV. □ V.

□ Comments/Restrictions _____

Referred for: □ BP □ Scoliosis □ Weight □ Murmur □ Other _____

□ **Physically qualified for participation in sports**, full playground, and school activities, or as indicated below (☑ or circle):
□ Contact/Collision: Field Hockey, Football, Ice Hockey, Soccer, Wrestling, Lacrosse.
□ Limited (Contact/Impact): Baseball, Basketball, Diving, Gymnastics, Skiing, Softball, Volleyball.
□ Strenuous/Non-contact: Cross Country, Track & Field, Swimming, Tennis, Cheerleading.
□ Non-strenuous/Non-Contact: Bowling, Golf

□ **Physically qualified for employment** □ Known or suspected disability: _____
□ Restrictions: _____

Provider Name (please print): _____

Provider Signature: _____

Phone Number: _____ Date: ____/_____/_____

Physician Stamp

Rev. 5/11
Physical Exam (Part B)
Health History (Part A) on back should be completed by parent / guardian

NIAGARA WHEATFIELD CENTRAL SCHOOL DISTRICT
Health History: 20____ - 20____ School Year

Name: _____ □ M □ F Date of Birth: _____ Grade_____

HEALTH HISTORY SHOULD BE COMPLETED FOR ALL STUDENTS PRIOR TO PHYSICAL

HEALTH HISTORY To be completed by parent /guardian.
Has your child ever had, or currently has, any of the following: (please check) ***Fill in below if Yes

		YES	NO	Date
1.	Does student have an ongoing medical condition (i.e. diabetes/hypoglycemia, asthma)?	_____	_____	_____
2.	Elevated blood pressure/heart problems/murmur/chest pains	_____	_____	_____
3.	Has physician ever said student has allergies/hay fever asthma?	_____	_____	_____
4.	Insect sting allergy (type) _____	_____	_____	_____
5.	Has student ever passed out or nearly passed out during or after exercise?	_____	_____	_____
6.	Does student cough, wheeze, or have difficulty breathing during or after exercise?	_____	_____	_____
7.	Has student ever used inhaler or taken asthma medication?	_____	_____	_____
8.	Does anyone in the family have a heart problem?	_____	_____	_____
9.	Has student complained of heart skipping beats or racing during exercise?	_____	_____	_____
10.	When exercising in the heat, has student had severe muscle cramps, or become ill?	_____	_____	_____
11.	Has student ever had a head injury or concussion? How many?_____	_____	_____	_____
12.	Loss of consciousness due to injury?	_____	_____	_____
13.	Headaches/dizzy	_____	_____	_____
14.	Ever had a seizure/convulsion	_____	_____	_____
15.	Neck Injury	_____	_____	_____
16.	Injury to spleen	_____	_____	_____
17.	Kidney disease or injury	_____	_____	_____
18.	Joint sprains/ligament tear, muscle	_____	_____	_____
19.	Back problem	_____	_____	_____
20.	Knee problem	_____	_____	_____
21.	Ankle problem	_____	_____	_____
22.	Hernia	_____	_____	_____
Please circle:				
23.	Does your child wear dental bridges, plates/braces, special pads/protective equipment	_____	_____	_____
24.	Does your child wear glasses/contacts	_____	_____	_____

Does your child take any medication? Please list:
25. _____

FOR WOMEN:

26. At what age did you experience your first menstrual period?_____
27. How often does your period occur? _____ When was your last period? _____

*****PLEASE PROVIDE AN EXPLANATION FOR ALL YES ANSWERS:**

_____
_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

SIGNATURE OF PARENT_____ **Date** _____

PLEASE COMPLETE THE FOLLOWING:

- I authorize the Health Office to share this information with school personnel as needed.
- I authorize the information contained in this physical exam to be released to _____Health Office. I also give permission for the information to be faxed to the above health office at 215-_____.

_____ _____
Parent Name (Print) Parent Signature

Date:_____

Part A- Health History form must be completed.