

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

	1 st	2 nd	3 rd	4 th	5 th
DtaP	*	*	*	*	*
Polio <input type="checkbox"/> IPV <input type="checkbox"/> OPV	*	*	*		
HIB					
Tdap		Tetanus	(Td)		
Hepatitis B	*	*	*		
MMR	*	*			
Varivax	*		<input type="checkbox"/> Disease	___/___/___	
Pneumococcal	*	*	*	*	

*4 IPV only

Screening Must Be Completed

Vision: Distance <input type="checkbox"/> Unaided	R	L
Vision: Distance <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses	R	L
Vision: Near Point <input type="checkbox"/> Unaided	R	L
Vision: Near Point <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses	R	L
Hearing: <input type="checkbox"/> Pass 20dB both ears or as indicated <input type="checkbox"/> Screening <input type="checkbox"/> 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: _____

	<u>Normal</u>	<u>Abnormal</u>
General Appearance	_____	_____
Nutrition	_____	_____
Skin	_____	_____
Head	_____	_____
Eyes	_____	_____
Ears	_____	_____
Nose/Throat	_____	_____
Teeth	_____	_____
Neck: Nodes/Thyroid	_____	_____
Lungs	_____	_____
Heart/Murmur	_____	_____
Pulses	_____	_____
Abdomen	_____	_____
Genitalia	_____	_____
Neurological	_____	_____
Musculoskeletal	_____	_____
Scoliosis	<input type="checkbox"/> Negative	<input type="checkbox"/> 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 _____

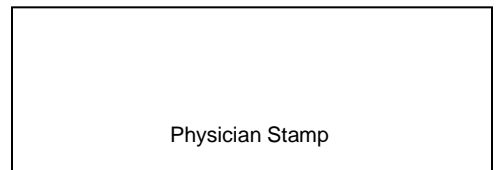
- Physically qualified for participation in sports**, full playground, and school activities, or as indicated below (or circle):
- Contact/Collision:** Field Hockey, Football, Ice Hockey, Soccer, Wrestling, Lacrosse.
- Limited (Contact/Impact):** Baseball, Basketball, Diving, Gymnastics, Skiing, Softball, 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: ___/___/___



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: _____