

ST. DOMINIC HIGH SCHOOL
110 ANSTICE STREET
OYSTER BAY, NEW YORK 11771

PHYSICAL EXAMINATION

STUDENT _____

BIRTH DATE _____

PHYSICAL EXAMINATION: Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school and all children in grades K, 2, 4, 7 and 10 will be examined by the school physician if no report is received. **An annual physical examination is required for participation in interscholastic sports. (*Both pages must be completed)**

- | | |
|---|--|
| 1. Height _____ Weight _____
Body Mass Index: _____
Weight Status Category (BMI Percentile)
less than 5 th 5 th -49 th 50-84 th
85 th -94 th 95 th -98 th 99 th and higher
BP _____ Pulse _____ | 12. Tonsils _____ |
| 2. Urinalysis _____ | 13. Teeth and Gums _____ |
| 3. Heart _____ | 14. Skin _____ |
| 4. Breasts _____ | 15. Glands (cervical, thyroid, other) _____ |
| 5. Lungs _____ | 16. Nervous System _____ |
| 6. Eyes R _____ L _____
With glasses R _____ L _____ | 17. Hernia _____ |
| 7. Visual Diagnosis _____ | 18. Genitourinary _____ |
| 8. Ears: Otosopic _____
Audiometric _____
P.E. Tubes: Yes _____ No _____ | 19. External genitalia _____ |
| 9. Speech _____ | 20. Tanner I II III IV V |
| 10. Nose _____ | 21. Orthopedic: Scoliosis _____
posture _____ feet: _____
structural defects _____ |
| 11. Throat _____ | 22. Abdomen _____ |

SURGERIES: _____

SIGNIFICANT ILLNESSES / INJURIES _____

ALLERGIES: _____

ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM

Full Activity _____ Restriction _____ Recommendation _____

CURRENT MEDICATIONS (please list all medications and doses):

IMMUNIZATION UPDATE: (please fill in or attach record of immunization)

PROCEDURES/TESTS:

- | | | |
|-----------------------------------|-----------------------------------|------------------------|
| DPT (or DT) _____
(3 required) | MMR _____
(2 measles required) | TB Screening _____ |
| DPT (or DT) Booster _____ | Hep B _____
(3 required) | Chest X-Ray _____ |
| Tetanus Booster _____ | HIB _____ | Lead Screening _____ |
| Polio (TOPV) _____ | Chicken Pox _____ | Sickle cell test _____ |
| Lyme disease _____ | | |
| Other _____ | Additional Procedures _____ | |

Signature of examining physician _____ Date _____ Print Name _____

Physician's Address & Phone: _____
(PLEASE STAMP)

INTERSCHOLASTIC SPORTS HEALTH EXAMINATION

Please complete both sides for participation in interscholastic sports.

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year except those crossed out below.

CONTACT/COLLISION	LIMITED CONTACT/IMPACT	STRENUOUS NON-CONTACT	NON-STRENUOUS/ NON-CONTACT
Field Hockey Football Ice Hockey Lacrosse Soccer Wrestling	Baseball Basketball Diving Gymnastics Handball Skiing Cross-Country Downhill Softball Volleyball	Crew Cross Country Track & Field Swimming Tennis	Archery Bowling Golf Riflery

Physician Signature: _____ Date: _____
Family Physician

The school physician has the final responsibility for the determination of a student's physical eligibility to participate in interscholastic sports. This is in compliance with the State Education Department Regulation 135.4 (7)(h).

Physician Signature: _____ Date: _____
School Physician

I give my child permission to participate on all interscholastic athletic teams at school except:

Signature: _____ Date: _____
Parent/Guardian