ROSLYN PUBLIC SCHOOLS 2010- 2011 ROSLYN HIGH SCHOOL

MEDICAL HEALTH FORM Required for Grades 7, 10 and new entrants. Failure to return this medical report will result in the school physician examining your child. **ORIGINAL MUST BE DATED AFTER APRIL 1st TO BE USED FOR INTERSCHOLASTIC SPORTS GRADES 7-12.**

NAME____________________________ GRADE____________

ADDRESS ______________________________________

Date of Birth___________Age____ ☐ Male ☐ Female

PARENT'S NAME (or Guardian)

Mother_______________________________________
Name

____

Phone/Home Business Beeper/cell

Father_______________________________________
Name

____

Phone/Home Business Beeper/cell

PHYSICIAN to be called in emergency:

____

Name Phone

PERSON other than parent to be called in emergency:

____

Name/Relationship Phone

HEALTH HISTORY (TO BE COMPLETED BY PARENT)

Allergies______________ Heart Disease___________

______________________ Kidney Disease__________

______________________ Mononucleosis___________

Asthma________________ Diabetes________________

Congenital Defect_____ Seizure Disorder_________

______________________ Strep/Scarlet Fever_______

Other____

DATES AND DESCRIPTIONS

Operations ___________________________________

Serious Injuries ______________________________

IMMUNIZATIONS – Given this calendar year
(TO BE COMPLETED BY PHYSICIAN)

Initial Series Measles_________________

DPT 1st__________ Mumps_________________

2nd__________ Rubella_________________

3rd__________ MMR #1_________________

TDAP _______________ MMR #2_________________

DT 1st__________ HIB ____________________

2nd__________ Polio 1st______________

3rd__________ 2nd______________

or Boosters:_________ 3rd______________

HEP. B_____________ Boosters:______________

____________________ TB (PPD)_____Results____

____________________ HIB____________________

Varicella____________ Varicella Disease_________

TO BE COMPLETED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN NEW YORK STATE

GRADES 7-12 **COMPLETE FOR SPORTS PHYSICAL***

Resting Pulse*_____________BMI_______%____________

Blood Pressure* ____/______Eyes___________________

Height*___________________Weight*________________

Lymph Nodes______________Thyroid________________

Nose_____________________Tonsils________________

Heart_____________________Lungs_________________

Hernia____________________Genito-urinary__________

Ortho-Struc.________________Scoliosis______________

Feet______________________Skin (non-comm.)_________

Seizure Disorder___________Other__________________

Defects (specify)_____________________________________

Recommendations ____________________________________

Hearing R ____________L ___________________________

Vision R 20/__________L 20/__________________________

W/Glasses R20/ L20/ W/Contacts R20/ L20/

SEVERE MYOPIA (20/200 OR MORE EITHER EYE) REQUIRES OPTHALMOLOGICAL CLEARANCE FOR CONTACT SPORTS.

STUDENT CAN PARTICIPATE IN ALL INTER-SCHOLASTIC CONTACT/COLLISION SPORTS WITHOUT RESTRICTION.

____

Physician's Signature

____

Physician's Name Printed

____

Physician's Address

___/___/______________________________________

DATE OF EXAM* Phone Number

MUST BE DATED AFTER APRIL 1st.

MAIL TO: HEALTH OFFICE
Roslyn High School
Round Hill Road
Roslyn Heights, NY 11577

**TO BE COMPLETED BY PARENT REQUESTING SCHOOL PHYSICAL:

I give permission for my son/daughter to be examined by the School Physician.

Parent's Signature _________________________________ Date _______________

Co signature School Physician _________________________ Date _______________

Rev. 9/2008