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

Regulation of the Chancellor

PART 1 to be filed in Student's Health folder

OSIS # _____ I.D. # _____
NAME: _____ SCHOOL: _____ BOROUGH: _____
ADDRESS: _____ HOMEROOM: _____ GRADE: _____
_____ DATE OF BIRTH: _____
TELEPHONE: _____ EMERGENCY TELEPHONE: _____
SPORT: _____
SPORT: _____

PARENTAL PERMISSION: I have reviewed the **STUDENT MEDICAL HISTORY** section below and I agree with the answers. I give permission for _____ to have a physical examination. I understand that completion of the Maturation Index is optional.

SIGNATURE: _____
DATE: _____ RELATIONSHIP: _____
********** **********

CLINICIAN'S RECOMMENDATIONS

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

(1) May participate in the following sports:
DRAW A LINE TRHOUGH ANY SPORTS TO BE OMITTED:

CONTACT	ENDURANCE	OTHER
Football	Gymnastics	Bowling
Baseball	Swimming	Golf
Basketball	Track & Field	Crew
Soccer	Cross-country	Cheerleading
Hockey	Tennis	Field Events
Wrestling	Volleyball	Archery
Lacrosse	Handball	
Softball	Fencing	
Cricket	Double Dutch	
Rugby		

DATE OF LAST TETANUS BOOSTER: _____

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

DATE: _____ SIGNATURE: _____
(CLINICIAN)
TELEPHONE: _____ NAME: (PRINT) _____
REGISTRY #: _____ ADDRESS: _____
_____

STUDENT'S MEDICAL HISTORY

(To be filled out by student and parent) Clinician's Comments

Has anyone in your family under age 45 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 ___
Have you ever had:
Hearing loss or deafness? Yes ___ No ___
Perforated ear drum or "tubes" in ears? Yes ___ No ___
Draining ears? Yes ___ No ___

PART 1 – STUDENT'S HEALTH FOLDER
STUDENT'S MEDICAL HISTORY **CONTINUED:**

(To be filled out by student and parent) Clinician's Comments

Have you ever had:
Sinus problems or hay fever? Yes ___ No ___
Braces or removable teeth? Yes ___ No ___
Have you ever had:
Any broken bones? _____ Yes ___ No ___
Dislocation or other serious problems? Yes ___ No ___
Serious foot problem? 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 problem? 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 medicine) 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 ___
Kidney problems? Yes ___ No ___
Skin infections? 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 ___

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PHYSICAL EXAMINATION

A complete physical examination for all students is recommended. Omission of the Maturation Index will not disqualify a student from participation.

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision Uncorrected: L20/_____ R20/_____ Corrected: L20/_____ R20/_____

	Normal	Abnormal	Comments
Skin	_____	_____	_____
Eyes	_____	_____	_____
ENT	_____	_____	_____
Mouth & Teeth	_____	_____	_____
Neck	_____	_____	_____
Cardiovascular	_____	_____	_____
Lungs, Chest	_____	_____	_____
Spine	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (Hernia)	_____	_____	_____