CAIRO-DURHAM CENTRAL SCHOOL DISTRICT

STUDENTS NAME_____**SPORT**_____
V/JV/MOD M/F
STUDENT'S ADDRESS_____
DATE OF BIRTH_____**YEAR ENTERED 9TH GRADE**_____
PARENT'S NAME AND ADDRESS_____
PHONE_____
WORK PHONE_____**CELL PHONE**_____
PHYSICIAN'S NAME_____**PHONE**_____
IN AN EMERGENCY:CONTACT_____**PHONE**_____
ALLERGIES:_____
MEDICALCONCERNS:_____
_____
_____

THIS CARD FULLY FILLED OUT AND SIGNED BY THE HEALTH OFFICE, PARENT, AND THE ATHLETIC DIRECTOR AUTHORIZES THE ATHLETE TO PARTICIPATE IN INTERSCHOLASTIC SPORTS.

FURTHER: A PERSONAL HISTORY SCREENING HAS BEEN SUCCESSFULLY COMPLETED, A PHYSICAL EXAM, AND THE PARENTS OF THE ATHLETE HAVE AUTHORIZED THE COACH TO SEEK EMERGENCY MEDICAL ASSISTANCE IN THE EVENT OF AN INJURY.

PARENT'S SIGNATURE_____**DATE**_____
NURSE'S SIGNATURE_____**DATE**_____
ATHLETIC DIRECTOR'S SIGNATURE_____**DATE**_____

******ALL SIGNATURES ARE REQUIRED PRIOR TO PRACTICE OR PARTICIPATION IN ANY ACTIVITY***********

FOR SCHOOL PHYSICIAN USE ONLY

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year 20__ to 20__.

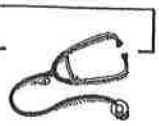
Any unmarked categories indicates disqualification from the particular group of sports activities.

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

_____
School Physician's Signature

_____
Date

School Health Services



INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

SCHOOL NAME: _____

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Student: _____ Age: _____

Grade (check): ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 Date of Birth: ____ /____ /____

Sport: _____ Level (check): ❑ Varsity ❑ JV ❑ Frosh ❑ Jr. High

Date of last health appraisal: _____/_____/_____ Limitations: ❑ Yes ❑ No

PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it may require a review and approval by the school physician before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL:

Allergies (Bee Sting/Medications/Food/Latex,etc.)	❑ Yes	❑ No
Does the student carry an Epi-pen for a life-threatening allergy?	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Does the student carry an inhaler?	❑ Yes	❑ No
Concussion/Head injury/Seizures	❑ Yes	❑ No
Recent injury that requires medical attention or protective equipment?	❑ Yes	❑ No
Recent illness lasting longer than one week (ie. Mono)	❑ Yes	❑ No
Currently taking medications	❑ Yes	❑ No
Diabetes/Hypoglycemia	❑ Yes	❑ No
Heart/Blood Pressure Problems	❑ Yes	❑ No
Heat Exhaustion or Stroke	❑ Yes	❑ No
Hearing Impairment	❑ Yes	❑ No
Bleeding Tendency/Anemia	❑ Yes	❑ No
Recent Surgery or Hospitalization	❑ Yes	❑ No
Kidney/Liver Disease	❑ Yes	❑ No
Contact Lenses	❑ Yes	❑ No
Is there any medical condition that might be aggravated by playing sports?	❑ Yes	❑ No

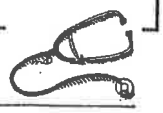
PART C: TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES".

_____

_____

_____



_____

_____

_____

PART D: PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ DATE: ____/____/____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation:

❑ Approved ❑ Referred to School Physician

Signed:_____ Date:____/____/____
School Health Office

If referred to the School Physician:

❑ Requalified ❑ Disqualified

Signed:_____ Date:____/____/____
School Physician

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: ☐ M ☐ F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____ _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

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

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scollosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/3/07*