

Physical will be conducted on:
Date: _____
Time: _____

Grade _____

ATHLETIC HEALTH HISTORY

SCHOOL NAME: _____

STUDENT: _____ DOB: _____

Participation in athletics is voluntary and is not a required part of the regular physical education program.

SPORTS ACTIVITIES

Identify any sports in which you do not wish your child to participate:

***THIS FORM MUST BE COMPLETED AND RETURNED ON THE DAY THE ATHLETE HAS HIS/HER PHYSICAL. THE APPOINTMENT DATE FOR THE PHYSICAL EXAMINATION IS IN THE UPPER LEFT HAND CORNER.**

HEALTH HISTORY TO BE COMPLETED BY PARENT

Has your child ever had: (please circle)

Allergies/Hay Fever	YES	NO	Elevated Blood Pressure	YES	NO
Bee Sting Allergy	YES	NO	Headaches	YES	NO
Asthma**	YES	NO	Head Injury/Concussion /Fainting	YES	NO
Anemia	YES	NO	Heart Problem/Murmur-Chest pain	YES	NO
Arthritis	YES	NO	Nose Bleeds/Frequent or Severe	YES	NO
Bladder/Kidney Problem or Injury	YES	NO	Ankle Injury	YES	NO
Convulsions/Seizures	YES	NO	Back Pain/Injury	YES	NO
Fainting Spells	YES	NO	Fracture-Dislocation Bones/Joints	YES	NO
Diabetes	YES	NO	Knee Pain/Injury	YES	NO
Ear Problems/Hearing Loss	YES	NO	Neck Injury	YES	NO
Eye Problems/Vision Loss	YES	NO	Nose Fracture	YES	NO
Injury to the Spleen	YES	NO	Hernia	YES	NO
Joint Sprain/Ligament Tear/Muscle Pull	YES	NO			

**For Asthma, please list all medications your child is taking, including daily and as needed inhalers:

Last time inhaler prescription was filled: _____

Please list any allergies and reactions: _____

Please list any medications, with dosage your child is currently taking: _____

Please list the medications, with dosage, your child takes during school hours: _____

Please circle Yes or No

Is your child under doctor's care now?	YES	NO
Is there a current medical examination on file in the nurse's office?	YES	NO
Is your child assigned to the CSE or 504 Program	YES	NO
Has your child been unconscious or lost memory from a blow on the head?	YES	NO
If yes, please give the approximate date _____		
Does your child have any of the following:		
One eye or severe uncorrectable loss of vision in one or both eyes	YES	NO
Severe hearing loss in both ears	YES	NO
One kidney	YES	NO
One testicle	YES	NO
Has your child been ill for five (5) consecutive days?	YES	NO
If yes, please provide more detail _____		

Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; require an operation; caused your child to miss a game or practice?	YES	NO
Has your child ever fainted during exercise?	YES	NO
If so, explain _____		
Has there ever been sudden death in a family member under fifty (50) years of age?	YES	NO
If yes, please explain _____		
Does your child have:		
Orthodontic appliances?	YES	NO
Capped teeth?	YES	NO
Braces/Retainers	YES	NO
Mouth Guard	YES	NO
Wear contact lenses for sports?	YES	NO
Wear glasses for sports?	YES	NO
Since your child's last physical examination, has your child had any injury or illnesses?	YES	NO
If yes, please explain _____		
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?	YES	NO

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT SIGNATURE: _____ **Date:** _____

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: _____

				Referral
Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: 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, bow, 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

**NAVAL JUNIOR RESERVE OFFICERS TRAINING CORPS
(NJROTC)
STANDARD RELEASE FORM**

Date: _____

I, _____, being the legal parent/guardian of _____, a member of the Naval Junior Reserve Officers Training Corps, in consideration of the continuance of his/her membership in the Naval Junior Reserve Officers Training Corps and/or his/her acceptance for Naval Junior Reserve Officers Training Corps training, do hereby release from any and all claims, demands, actions, or causes of action, due to death, injury, or illness, the government of the United States and all its officers, representatives, and agents acting officially and also the local, regional, and national Navy Officials of the United States.

I hereby authorize personnel of the Department of Defense, Armed Forces, Public Health Service, or civilian physicians to render such medical and dental care as may be necessary and medically indicated in the case of my son/daughter/ward during his/her period of training, as is deemed necessary by a qualified practitioner.

I understand that care at a military medical facility for non-military dependents will normally be rendered on a temporary (emergency) basis only: if further care is indicated, the patient will be transferred to non-military care as soon as possible. Emergency care provided to cadets who are not military dependents at a military facility may be subjected to reimbursement, and I may be billed for the care provided. For Navy Medical Department facilities, such care is authorized by NAVMEDCOMINST 6320.3B.

My son/daughter/ward has been determined to have the following allergies:

He/she requires medication for the treatment of:

Below are listed other medical conditions which my son/daughter/ward is known to have, which would preclude or limit in any way his/her participation in physical exercise and athletic programs.

His/her physician is:

Name:

Address:

Telephone (include area code):

Medical Insurance Company *		
Name:		
Street:		
City, State, Zip Code:		
Policy/ID Number:		
Telephone Confirmation Number: ()		

Dental Insurance Company*		
Name:		
Street:		
City, State, Zip Code:		
Policy/ID Number:		
Telephone Confirmation Number: ()		

***This insurance is not required. However, the information provided may be required to obtain non-emergency care.**

PRIVACY ACT NOTIFICATION
 Under the authority of 5 U.S.C. Sec. 301, the information regarding your child's/ward's health, medical condition and treatment is requested in order to verify any need to administer medication and to enable medical/dental personnel to diagnose and treat any emergency condition which may arise during training. Pursuant to the Privacy Act, 5 U.S.C. Sec. 552, the requested information will not be divulged without your written authorization to anyone other than NJROTC area personnel involved with administration of NJROTC activities and medical/dental personnel requiring the information in order to effectively treat any medical/dental problem which may arise. Disclosure is voluntary; however, failure to provide the requested information will preclude your child's/ward's participation in the training.

Signature of Parent or Guardian:		
Address:		
City:	State:	Zip:
Telephone (include area code):		



Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT _____ *Please print or type clearly*

SCHOOL _____ GRADE _____

STUDENT NAME _____

DATE OF BIRTH _____
Month: _____ Day: _____ Year: _____

STUDENT IDENTIFICATION NUMBER _____

COUNTRY OF BIRTH / ANCESTRY _____

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S. _____

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION _____

DETERMINATION: Possible LEP
 English Proficient

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence? English Other _____ *specify*
- What language(s) are spoken most of the time to the student, in the home or residence? English Other _____ *specify*
- What language(s) does the student understand? English Other _____ *specify*
- What language(s) does the student speak? English Other _____ *specify*
- What language(s) does the student read? English Other _____ Does Not Read *specify*
- What language(s) does the student write? English Other _____ Does Not Write *specify*

7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	Only a little	Not at all
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Month: _____ Day: _____ Year: _____

Signature of Parent/Guardian/Other _____

Date _____



CUESTIONARIO SOBRE EL IDIOMA QUE SE HABLA EN EL HOGAR
("Home Language Questionnaire, HLQ") - Spanish

*Estimado Padre/Madre o Guardián:
Para poder ofrecer a su hijo(a) la mejor
educación posible, necesitamos
determinar cuán efectivamente él o ella
entiende, habla, lee y escribe el idioma
inglés. Su ayuda será apreciada si
contesta estas preguntas.*

Gracias.

**PARA SER COMPLETADO POR EL PERSONAL ESCOLAR
(TO BE COMPLETED BY SCHOOL PERSONNEL)**

DISTRITO (District)	IMPRIMA O ESCRIBA CLARAMENTE (Please print or type Clearly)		
ESCUELA (School)	GRADO (Grade)		
NOMBRE DEL ESTUDIANTE (Student Name)			
FECHA DE NACIMIENTO (Date Of Birth)			
Mes: (Month)	Día: (Day)	Año: (Year)	
NUMERO DE IDENTIFICACION DEL ESTUDIANTE (Student Identification Number)			
PAIS NATALO ASCENDENCIA (Country of Birth/Ancestry)			
NUMERO DE AÑOS MATRICULADO EN ESCUELA(S) FUERA DE LOS E.U. (Number of years enrolled in school outside the U.S.)			
NOMBRE/POSICIÓN DEL PERSONAL ESCOLAR LLENANDO ESTA SECCION (Name/Position School Personnel Completing This Section)			
DETERMINACIÓN: (Determination)	<input type="checkbox"/> Posiblemente LEP (Possibly LEP) <input type="checkbox"/> Dominante en Inglés (English Proficient)		

(✓ Marque las casillas que aplican)

- ¿Qué idioma(s) se habla en el hogar o residencia del estudiante?

<input type="checkbox"/> Inglés	<input type="checkbox"/> Español	<input type="checkbox"/> Otro _____
<i>(Especifique cuál)</i>		
- ¿En qué idioma(s) se le habla al estudiante la mayor parte del tiempo en el hogar o residencia?

<input type="checkbox"/> Inglés	<input type="checkbox"/> Español	<input type="checkbox"/> Otro _____
<i>(Especifique cuál)</i>		
- ¿Qué idioma(s) entiende el estudiante?

<input type="checkbox"/> Inglés	<input type="checkbox"/> Español	<input type="checkbox"/> Otro _____
<i>(Especifique cuál)</i>		
- ¿Qué idioma(s) habla el estudiante?

<input type="checkbox"/> Inglés	<input type="checkbox"/> Español	<input type="checkbox"/> Otro _____
<i>(Especifique cuál)</i>		
- ¿En qué idioma(s) lee el estudiante?

<input type="checkbox"/> Inglés	<input type="checkbox"/> Español	<input type="checkbox"/> Otro _____	<input type="checkbox"/> No lee
<i>(Qué idioma)</i>			
- ¿En qué idioma(s) escribe el estudiante?

<input type="checkbox"/> Inglés	<input type="checkbox"/> Español	<input type="checkbox"/> Otro _____	<input type="checkbox"/> No escribe
<i>(Qué idioma)</i>			
- ¿En su opinión, qué tan bien el estudiante entiende, habla, lee y escribe inglés?

	Muy bien	Un poco	Nada
Entiende Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Habla Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lee Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Escribe Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Firma del Padre/Madre/Guardián/Otro
(Signature of Parent/Guardian/Other)

Mes:
(Month)
Fecha
(Date)

Día:
(Day)

Año:
(Year)