

OACSD PRE-PARTICIPATION HEALTH UPDATE

NAME _____ DATE _____ SEX _____ AGE _____ GRADE _____

SPORT _____ PERSONAL PHYSICIAN _____

PHYSICIAN ADDRESS _____

COMPLETE THIS SECTION FOR EACH SPORT OF EACH SCHOOL YEAR

			MUST HAVE	
	NO	YES	DATES	DESCRIPTION
1. Have you ever been hospitalized?	_____	_____	_____	_____
2. Have you had surgery?	_____	_____	_____	_____
3. Have you been treated in an emergency room?	_____	_____	_____	_____
4. Any injury requiring medical attention?	_____	_____	_____	_____
5. Illness requiring Physician's care?	_____	_____	_____	_____
6. Are you presently taking any medication?	_____	_____	_____	_____
7. Do you have any allergies?	_____	_____	_____	_____
8. Feeling of faintness or dizziness with exercise?	_____	_____	_____	_____
9. Chest pain during or after exercise?	_____	_____	_____	_____
10. Do you tire more quickly than your friends during exercise?	_____	_____	_____	_____
11. Have you ever had high blood pressure?	_____	_____	_____	_____
12. Have you ever been told that you have a heart murmur?	_____	_____	_____	_____
13. Have you ever had racing of your heart or skipped heartbeats?	_____	_____	_____	_____
14. Have any of your relatives died of heart problems or sudden death before the age of 50?	_____	_____	_____	_____
15. Have you had a head injury or been diagnosed with a concussion?	_____	_____	_____	_____
16. Have you ever been knocked out or unconscious?	_____	_____	_____	_____
17. Have you ever had a seizure?	_____	_____	_____	_____
18. Have you ever had a stinger, burner, or pinched nerve?	_____	_____	_____	_____
19. Have you ever had heat illness?	_____	_____	_____	_____
20. Have you had trouble breathing or coughing during or after activity?	_____	_____	_____	_____
21. Do you use any special equipment (pads, braces, eye guards, neck rolls, contacts, glasses)?	_____	_____	_____	_____
22. Have you had difficulty with eye, vision or hearing?	_____	_____	_____	_____
23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling, or other injuries to any bones or joints?	_____	_____	_____	_____
24. Have you ever had a medical problem (Diabetes, infectious mononucleosis, etc.)?	_____	_____	_____	_____
25. Have you had ANY medical problem or injury SINCE YOUR LAST PHYSICAL?	_____	_____	_____	_____
26. Are you missing an eye or kidney?	_____	_____	_____	_____

Girls: When was your first menstrual period? _____ When was your last? _____

Boys: Do you have an undescended or missing testicle? _____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I also agree to Emergency Medical treatments as deemed necessary by the designated school authorities.

Athlete Signature: _____

Date: _____

Parent Signature: _____

Date: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
---	---	---

Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
--	--	--

Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
--	--	--

Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
--	---	---

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 **Percentile (Weight Status Category):** <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:	DOB:
-------	------

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			

Recommendations:
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications

No Contact Sports **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

No Non-Contact Sports **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY
 Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports
 Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

Order Form for Medication(s) Needed at School attached

List medications taken at home:		

IMMUNIZATIONS

Record Attached Reported in NYSIIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child’s School When Entirely Completed.