EAST MORICHES UNION FREE SCHOOL DISTRICT
Sports Physical Form

Name: _____ Date of Birth: _____ Grade: _____ M/F
Home Phone: _____ Parents Work #: _____ Ht. _____ Wt. _____

IS THERE A HISTORY OF:

Heart Disease		Bladder Disorder		Head Injury	
Lung Disorder		Seizure Disorder		Diabetes	
Blood Disorder		Abdominal Disorder		Muscle Disorder	
Kidney Disorder		Hernia		Nerve Disorder	

Injury To:
Knee Cartilage _____ Other Joint _____
Fracture _____ Complicated _____
Uncomplicated _____

Allergy To:
Antibiotics, Other Medications _____
Including Tetanus Vaccine _____
Pollen, Mold, etc. _____
Bee's _____ Other Insects _____
Foods _____ Other _____

Any Medications _____

***PHYSICAL EXAMINATION (N = NORMAL P = PATHOLOGY) Summary of positive findings to be explained on reverse side.**

Eyes _____ Glasses _____ Contacts _____ Lungs _____
Ears: Otoscopic _____ Dental _____ Heart _____ Skin _____
Hernia _____ Speech _____ Scoliosis _____ Abdomen _____
Nutrition _____ Orthopedic _____ Problem _____ Extremities _____

Blood Pressure: _____ Resting Heart Rate _____ 30 Sec. Jumping Jacks _____
Rate after 2 min. rest _____ Urine; sugar _____ Protein _____

All lines must be completed to be valid. Indicate any known congenital defects on the reverse side. If pathology exits, further consultation and work-up is required. This certifies the student in physically qualified to participate in the following categories during the school year 20__ - 20 __.

Contact or Collision Sports
Baseball, Soccer, Football, Wrestling, Basketball, Softball, Lacrosse

Endurance Activities
Track/Cross Country, Volleyball

PLEASE INDICATE ANY SPORT THE CHILD MAY NOT QUALIFY FOR AND THE REASON FOR DISQUALIFCATION.

DATE: _____ SIGNED: _____
PMD Signature and Stamp School Physician

*If your child has had an injury that requires them to refrain from sports, you must provide the school nurse with a doctor's note. When they are able to resume sports, you must provide a doctor's note clearing them to resume sports.

East Moriches Union Free School District

This form must be completed and signed by a parent.

Date:_____ Student Name:_____
Phone:_____ Address:_____
Date of Birth:_____ Grade entering_____ Family Doctor:_____

FAMILY HISTORY

Has anyone in your family (parents, aunts, uncles, cousins, grandparents) ever had :
Check One

	Yes	No		Yes	No
DIABETES	_____	_____	Tendency to bleed	_____	_____
ALLERGIES	_____	_____	ANEMIA	_____	_____
HAY FEVER	_____	_____	HEART DISEASE	_____	_____
Reaction to medicine	_____	_____	STROKE	_____	_____
Reaction to insect stings	_____	_____	HIGH BLOOD PRESSURE	_____	_____
TUBERCULOSIS	_____	_____	Irregular heart beat	_____	_____
High Cholesterol	_____	_____			
ASTHMA	_____	_____			

	Yes	No
Has anyone in your family under age 50 died suddenly?	_____	_____

Explain:_____

STUDENT HISTORY

CARDIOVASCULAR-RESPIRATORY;	YES	NO
Heart or Lung trouble	_____	_____
Chronic tiredness	_____	_____
Heart Murmur	_____	_____
High Blood Pressure	_____	_____
Chest pain with or without exercise	_____	_____
Persistent Cough	_____	_____
Dizziness, faintness or wheezing with Exercise	_____	_____
Rapid or Irregular Heart Beat	_____	_____
Shortness of Breath	_____	_____
Heart/lung x-ray or Cardiogram	_____	_____
Pneumonia	_____	_____
Exposure to Tuberculosis	_____	_____

METABOLIC:	YES	NO
Diabetes	_____	_____
Hypoglycemia	_____	_____
Prone to heat Exhaustion	_____	_____
Other: Specify_____		

BLOOD:	YES	NO
Tendency to bleed or bruise easily	_____	_____
Anemia	_____	_____
Hepatitis	_____	_____
Mononucleosis	_____	_____

BLOOD:	YES	NO
Jaundice	_____	_____
Any injury/Enlargement of Liver, kidneys or spleen	_____	_____

DIGESTIVE:	YES	NO
Frequent abdominal pain	_____	_____
Ulcers	_____	_____
Colitis	_____	_____
Enteritis	_____	_____

NEUROLOGICAL:	YES	NO
Brain Concussion		
Fainting Spells		
Skull fracture		
Recurring Severe Headaches		
Convulsions or Epilepsy		
Lyme Disease		

GENITO URINARY:	YES	NO
Hernia		
Blood/Pus or Protein in urine		
Impaired function or loss of a kidney		
Urinary tract infections		
Absence of testicle		
Menstrual Problems		

Age at onset of menstruation_____

EYES/EARS/NOSE/ THROAT	YES	NO
Very bad vision in one eye R/L		
Temporary loss of vision		
Glasses		
Contacts		
Hearing Loss		
Perforated ear drum (R/L)		
Recurrent ear infections		
Sinus infection		
Rheumatic Fever		
Frequent Nose Bleeds		
Broken Nose		
Deviated Septum		
Dental Plate/Dentures		
Orthodontia(Braces)		
Hearing Aide		

ORTHOPEDIC:	YES	NO
Bone Fracture		
Joint Dislocation		
Operations on bones		
Foot problems		
Spine or limb deformity		
Neck injury		
Back injury or Frequent backaches		
Knee injury or recurrent pain		
Other joint problems		
Bone Infection		

ALLERGY:	YES	NO
Hay fever		
Asthma		
Frequent hives or Rash		
Reaction to medication Specify		
Reaction to insect Stings		

DOES YOUR CHILD:	YES	NO
Take any medication regularly		
If yes, name_____		
Take medication in an Emergency		
If yes, type and date_____		
Has your child ever had an operation?		
If yes name_____		

Has your child ever been Hospitalized ? _____ Why/When?_____

Has your child ever been told to give up athletics because of a health problem?_____

Explain_____

IF THERE ARE ANY YES ANSWERS TO ANY OF THE ABOVE QUESTIONS PLEASE EXPLAIN:

SIGNATURE:_____Date_____

East Moriches Union Free School District
9 Adelaide Avenue
East Moriches, NY 11940

PERMISSION LETTER FOR CONTACT LENSES AND ORTHODONTIC APPLIANCES

My child, _____ has my permission to engage in all physical education programs and/or athletic activities while wearing his/her contact lenses and/or orthodontic appliances. I understand that there is a possibility of loss of or damage to the lenses or appliances during participation by my child in such activities. I recognize that the lenses and/or appliances can be lost, crushed or damaged during body contact activities ar other vigorous exercise. I am willing to take the calculated risks involved and assume responsibility for replacement of the above should they be lost or broken.

_____ Contact lenses

_____ Orthodontic Appliances

_____
Signature of Parent or Guardian

NOTE: PLEASE RETURN THIS SIGNED FORM TO THE SCHOOL NURSE.