



# Garden City Public Schools

## Medical Evaluation



TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student's Name \_\_\_\_\_ Male  Female

Grade \_\_\_\_\_ Teacher / Homeroom \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Physician to be called in emergency: \_\_\_\_\_ Telephone: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Telephone/Cell: \_\_\_\_\_

### TO BE COMPLETED BY PARENT OR GUARDIAN

#### STUDENT'S HEALTH HISTORY

Please check YES or NO to the following questions, if you answer yes to any questions explain below.

	YES	NO		YES	NO
1. Does your child have allergies? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	9. Has any family member or relative died of a heart problem, heart attack, stroke or a sudden unexplained death before the age of 50? <i>If YES explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child take any daily medications? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	10. Has a doctor ever ordered a test for your child's heart (i.e. echo, stress test)? <i>Type of test</i> _____ <i>When:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child have any on-going medical conditions (i.e. seizures, diabetes, asthma, ADHD)? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	11. Does anyone in your family have Marfan's syndrome, hypertrophic cardiomyopathy, long QT syndrome, or other cardiomyopathy? <i>If YES explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child cough, wheeze or have difficulty breathing DURING or IMMEDIATELY AFTER exercise? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	12. Was your child born without or is missing a kidney, eye, testicle or any other organ? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your child ever had surgery or been hospitalized overnight? <i>If YES explain</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	13. Has your child ever had a concussion or serious head injury? <i>If YES explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your child ever passed out or nearly passed out DURING exercise? <i>If YES explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	14. Has your child ever been hit in the head and been confused, lost memory after the injury or been unable to move arms or legs or felt weak? <i>If YES explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Has your child ever had pain/discomfort or pressure in their chest DURING exercise? <i>If YES explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>			
8. Has a doctor ever told you that your child has a heart murmur, heart problem, high blood pressure, high cholesterol or a heart infection? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>			

\* *I give permission for the school physician to examine my child.* YES  NO

Parent's Signature \_\_\_\_\_

### TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Exam: \_\_\_\_\_

Body Mass Index: \_\_\_\_\_

Weight Status Category (BMI Percentile)

Less than 5th <input type="checkbox"/>	5th thru 49th <input type="checkbox"/>	50th thru 84th <input type="checkbox"/>
85th thru 94th <input type="checkbox"/>	95th thru 98th <input type="checkbox"/>	99th and higher <input type="checkbox"/>

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Skin \_\_\_\_\_

EENT \_\_\_\_\_

Neck / Thyroid \_\_\_\_\_

Cardiovascular \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Genitalia (Tanner Stage) \_\_\_\_\_ /LNMP \_\_\_\_\_

Orthopedic: Structural Defect \_\_\_\_\_

Scoliosis \_\_\_\_\_

Nervous system \_\_\_\_\_

Do you approve this student for ALL Interscholastic Sports?  
YES  NO

Reason for disqualification \_\_\_\_\_

#### IMMUNIZATION UPDATE ONLY

DTaP \_\_\_\_\_

Tdap \_\_\_\_\_

DT/Td \_\_\_\_\_

IPV \_\_\_\_\_

HIB \_\_\_\_\_

HEP B \_\_\_\_\_

VARICELLA (Varivax) #1 \_\_\_\_\_ #2 \_\_\_\_\_

MMR #1 \_\_\_\_\_ #2 \_\_\_\_\_

MEASLES \_\_\_\_\_ MUMPS \_\_\_\_\_ RUBELLA \_\_\_\_\_

MENINGITIS (MCV4) #1 \_\_\_\_\_ #2 \_\_\_\_\_

OTHER VACCINE \_\_\_\_\_ date \_\_\_\_\_

OTHER VACCINE \_\_\_\_\_ date \_\_\_\_\_

BLOOD LEAD SCREENING \_\_\_\_\_

PPD: \_\_\_\_\_ Pos. \_\_\_\_\_ Neg. \_\_\_\_\_

Health Care Provider's Signature \_\_\_\_\_

Health Care Provider's Name (Please Print) \_\_\_\_\_

Health Care Provider's Address \_\_\_\_\_

Health Care Provider's Telephone \_\_\_\_\_

School Physician's Signature \_\_\_\_\_

