

Student Name _____
 Address _____
 Sex _____

Date of Birth _____
 Phone _____
 Grade _____

Height _____	Weight _____	Body Mass Index: _____	BMI Percentile _____ %
Weight Status Category		PLEASE ATTACH IMMUNIZATION RECORD	
<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	

	COMMENTS	URINALYSIS*	
General Appearance		* Urinalysis is required for sports participation	
Nutrition			
Skin		Glucose	Protein
Head		+ -	+ -
Eyes			
Ears			
Nose, Throat, Teeth			
Lymph Nodes/Thyroid		Blood Pressure (actual reading required)	
Lungs			
Heart			
Abdomen			
Genitalia			
Musculoskeletal		Scoliosis	Negative Positive
Neurological			

Significant Medical/Surgical History see attached _____

Asthma yes no

Allergies: None Food Insect Seasonal Medication LIFE THREATENING _____

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

Physically qualified for all sports, full physical education program, full playground OR only as checked below:

____ Contact/Collision: Field Hockey, Football, Ice Hockey, Lacrosse, Soccer, Wrestling

____ Limited contact: Baseball, Basketball, Diving, Gymnastics, Softball, Volleyball

____ Strenuous/Non-contact: Cheerleading, Kickline, Cross-country, Track/Field, Swimming/Tennis

____ Non-strenuous/ Non-contact: Archery, Bowling, Golf, Riflery

Physically qualified for employment OR specify accommodation _____

Known or suspected disability _____

Restrictions/Duration _____

NYS Education Department requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 & 10, sports, working permits, and, triennially, for the Committee on Special Education (CSE). This exam complies with NYSED requirements above and is valid for one year through the last day of the month dated below.

PROVIDER'S SIGNATURE _____ **Exam Date** _____

PROVIDER'S NAME/ STAMP (REQUIRED) _____ **Phone** _____ **Fax** _____

YELLOW SHEET

Massapequa Public Schools

**Medical Questionnaire for Interscholastic Sports
(to be completed by parent)**

Name _____ School _____
(Last Name, First Name)

Date of Birth _____ Grade _____

Instructions to parents: Please answer all questions by placing an "X" in the proper space.
Parent or guardian must sign in proper space.

Is there any history (past or present) of:

		Yes	No
1.	Seizures of convulsions (fits)		
2.	Fainting or repeated dizziness		
3.	Serious head injury or concussion		
4.	Loss of sight in one eye or serious disorder		
5.	Hearing loss (one or both)		
6.	Repeated or prolonged shortness of breath		
7.	Asthma attacks		
8.	Chronic cough or chest pain		
9.	Heart palpitations (skipped beats)		
10.	Heart murmur or heart condition		
11.	High blood pressure		
12.	Enlarged liver or spleen		
13.	Kidney disease or absence of one kidney		
14.	Bloody urine or bowel movement		
15.	Prolonged bleeding time or anemia		
16.	Hernia (rupture)		
17.	Any fractures (broken bones) or dislocations		
18.	Any muscle or joint problems		
19.	Diabetes		
20.	Boys only – One testicle absent		
21.	Girls only – Excessive menstrual bleeding		
22.	Any operation (other than tonsillectomy)		
23.	Allergies		
24.	Any illness lasting more than two weeks		
25.	Any other serious medical problem		
26.	Any other serious injury		

Explanation (for questions answered "Yes")

I have answered these questions to the best of my knowledge.

Signed: _____

Relationship: _____

Date: _____