

Cazenovia Central School Physical Form

Student _____ Age _____ Grade _____

Height _____ Weight _____ Blood Pressure _____ Urinalysis _____

Physical Exam

- 1. General...Appearance/ Condition.....
- 2. Eyes.....
- 3. Ears.....
- 4. Nose.....
- 5. Skin.....
- 6. Tonsils.....
- 7. Teeth.....
- 8. Thyroid.....
- 9. Lungs.....
- 10. Heart.....
- 11. Lymph...Nodes.....
- 12. Hernia.....
- 13. Orthopedic:
 - Scoliosis.....
 - Structure.....
 - Knees.....
 - Feet.....
- 14. Nutrition.....
- 15. Genitalia.....
- 16. Neurological (Epilepsy, etc).....
- 17. Other.....
- 18. Any chronic illnesses or conditions this child is treated for?.....
- 19. Does child require medication on regular basis/ prn basis?.....

Physician, please check appropriate box below:

- 1. Qualified for contact sports
- 2. Non-contact sport ONLY
- 3. Reason for disqualification _____

Date of last Tetanus Booster _____

Dates of hepatitis B 1. _____ 2. _____ 3. _____

Any other recent immunizations _____

Date of physical _____ Signature _____ M.D.

Printed name _____ Address _____

This certificate is void if pupil is absent from school five or more consecutive days due to illness or suffers a significant injury. A doctor must then issue new approval.

Pages 1 & 2 must be completed and returned

Confidential Health History to be completed by parent.

Name: _____

The health of children greatly influences their ability to learn. Please complete each item below and take this form to your physician at the time of your child's exam.

| Has your child ever had: (please check, explain, and date if yes) | No | Yes | Explanation |
|---|----|-----|-------------|
| Allergies (food, medication, hay fever) | | | |
| Anemia (low blood iron) | | | |
| Arthritis | | | |
| Asthma | | | |
| Bladder/ Kidney Problem or Injury | | | |
| Blood Pressure Problem (high/ low) | | | |
| Bee Sting Allergy | | | |
| Chicken Pox | | | |
| Congenital Defect | | | |
| Convulsion/ Seizure/ Epilepsy | | | |
| Diabetes | | | |
| Ear Problems/ Hearing Loss | | | |
| Encephalitis | | | |
| Eye problems/ Glasses/ Contacts | | | |
| Fainting Spells | | | |
| Head Injury/ Concussion | | | |
| Headaches/ Migraines | | | |
| Heart Problem/ Murmurs/ Chest Pains | | | |
| Hernia | | | |
| Injury to the spleen or other organs | | | |
| Infectious Mono Hepatitis | | | |
| Fracture, Dislocated (bones/ joints) | | | |
| Joint Sprain/Ligament Tear/ Muscle Pull | | | |
| Loss of a paired organ | | | |
| Meningitis | | | |
| Menstrual Cycle | | | |
| Nose Fracture/ Nose Bleeds | | | |
| Pneumonia | | | |
| Rheumatic fever | | | |
| Scarlet Fever | | | |
| Stomach Ulcer | | | |
| Tuberculosis | | | |
| Whooping Cough | | | |
| Illness lasting more than a week | | | |
| Hospitalized overnight | | | |
| Medication on a daily or prn basis at home | | | |
| Medications/ Inhalers during school hours/ Sports | | | |
| Surgery/ Operation | | | |
| Presently under a physician care | | | |

Has any Family Member under 50 years of age died of a heart problem? _____

Are there any special problems related to his/her health? _____

I acknowledge that the above information is correct: _____

Signature

Date