

NATIONAL YOUTH SPORTS PROGRAM FUND Medical Examination Record Intended for NYSP Participation Only

This confidential information should be made available only to the medical coordinator and physician.

City Name of parent/guardian _ Address of parent/guardian Telephone: Home Emergency Contact: Name:	ne First Nan	State	Zip Code	Birthda	MO	Age//
City Name of parent/guardian _ Address of parent/guardian Felephone: Home Emergency Contact: Name: Telephone: Home _	1	State	Zip Code	Birthda	MO	DAY YEAR
Name of parent/guardian _ Address of parent/guardian Felephone: Home Emergency Contact: Name: Telephone: Home _	1				МО	DAY YEAR
Address of parent/guardian Celephone: Home Cmergency Contact: Name: Telephone: Home	1					
Celephone: Home Cmergency Contact: Name: Telephone: Home _						
mergency Contact: Name: Telephone: Home _				Work		
Name: Telephone: Home _						
Telephone: Home_						
				Relations	ship: _	
Address:				Work: _		
	Street					
		State	Zip Code			
Family Doctor:				Telephon	ie:	
ATTENTION MEDICAL COO	RDINATOR:					
Referral:	A youth's parent/guar during the screening	or during th	ne course of the	project. A	n app	oropriate healt
Follow-up:	care agency also will When a health proble until the problem rece for such treatment ha existing medical prob with the conclusion of	m is discoverives property ve been explems or for	vered, the instituer treatment or un khausted. Institu problems unrel	ition shall p ntil all reas utional resp	oursu sonab oonsil	e the matter le opportunitie pility for pre-
	REFERRAL AN	ND FOLLO	W-UP PROCEDU	RE		
Parent/guardian and/or health	authorities notified of child's	s health deficie	ency Yes		No _	
Means of notification: Perso	nal Contact Telephon	e Lette	er Date of not	ification		
Noticeable improvement as o	of:	Yes				

List Allergies:		_ Hemophilia	a: Other:		 I	FOLLOW
		NORMAL	IF ABNORMAL, DESCRIBE HERE	NORMAL	YES	FOLLOW UP NO
cerumen)	ng, absence or					
Eyes (reflex visual acuit	kes, movements,					
Nose, Thro						
Gums	- · ,					
Teeth						
Neck						
Lungs						
Breasts Lymph Noc	los	+				
Heart	100	+				
Absence of	Hernia					
Back						
Skin						
Bones, Joint Nervous Sys						
Nervous Sys	otem					
			OPTIONAL			
	Chest X-Ray					
	Sickle Cell Prep Sugar	Wgt	Urine Albumin	Blood		
	_ Immunization R	ecord: Tets	nus	Boos	ster	
	Needed Y			Вооз	,,,,,	
		Date				
		Dinhtheria		Booster		
	Needed	Yes _	No Date			
	Needed	Polio Yes _	No Date	Booster		
	1	`	rent medications taken:			
General phy	sical condition					
May particip	oate in program	Yes	No			
Additional c	omments or recomm	endations				

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