ST. DOMINIC HIGH SCHOOL
110 ANSTICE STREET
OYSTER BAY, NEW YORK 11771

PHYSICAL EXAMINATION

STUDENT _____ BIRTH DATE _____

PHYSICAL EXAMINATION: Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school and all children in grades K, 2, 4, 7 and 10 will be examined by the school physician if no report is received. **An annual physical examination is required for participation in interscholastic sports. (*Both pages must be completed)**

1. Height_____ Weight _____
   Body Mass Index:_____
   Weight Status Category (BMI Percentile)
   __ less than 5th __5th-49th __50-84th
   __85th-94th __95th-98th __99th and higher
   BP _____ Pulse_____
2. Urinalysis _____
3. Heart_____
4. Breasts _____
5. Lungs _____
6. Eyes R_____ L _____
   With glasses R _____ L_____
7. Visual Diagnosis _____
8. Ears: Otoscopic
   Audiometric _____
   P.E. Tubes: Yes _____ No_____
9. Speech _____
10. Nose _____
11. Throat _____
12. Tonsils _____
13. Teeth and Gums _____
14. Skin _____
15. Glands (cervical, thyroid, other) _____
16. Nervous System_____
17. Hernia _____
18. Genitourinary _____
19. External genitalia _____
20. Tanner I II III IV V
21. Orthopedic: Scoliosis _____
    posture _____ feet: _____
    structural defects _
22. Abdomen _____

SURGERIES: _____

SIGNIFICANT ILLNESSES / INJURIES _____

ALLERGIES: _____

ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM

Full Activity _____ Restriction _____ Recommendation _____

CURRENT MEDICATIONS (please list all medications and doses):

_____

IMMUNIZATION UPDATE: (please fill in or attach record of immunization)

DPT (or DT) _____ _____ _____ (3 required)
DPT (or DT) Booster _____
Tetanus Booster _____ _____ _____
Polio (TOPV) _____
Lyme disease_____
Other _____

MMR _____ _____ (2 measles required)
Hep B _____ _____ _____ (3 required)
HIB _____ _____ _____
Chicken Pox _____

PROCEDURES/TESTS:

TB Screening _____
Chest X-Ray _____
Lead Screening _____
Sickle cell test _____
Additional Procedures _____

_____
Signature of examining physician Date Print Name

Physician's Address & Phone: _____
(PLEASE STAMP)

INTERSCHOLASTIC SPORTS HEALTH EXAMINATION

Please complete both sides for participation in interscholastic sports.

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year ***except*** those crossed out below.

CONTACT/COLLISION	LIMITED CONTACT/IMPACT	STRENUOUS NON-CONTACT	NON-STRENUOUS/ NON-CONTACT
Field Hockey Football Ice Hockey Lacrosse Soccer Wrestling	Baseball Basketball Diving Gymnastics Handball Skiing Cross-Country Downhill Softball Volleyball	Crew Cross Country Track & Field Swimming Tennis	Archery Bowling Golf Riflery

Physician Signature: _____ Date: _____
Family Physician

The school physician has the final responsibility for the determination of a student's physical eligibility to participate in interscholastic sports. This is in compliance with the State Education Department Regulation 135.4 (7)(h).

Physician Signature: _____ Date: _____
School Physician

I give my child permission to participate on all interscholastic athletic teams at school ***except***:

_____

_____

_____

Signature: _____ Date: _____
Parent/Guardian