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:** __________

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STUDENT'S HEALTH HISTORY **Date** __________

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

Question	YES	NO
1. **Do you have allergies?** *List:* ______________	☐	☐
2. **Do you take any daily medications?** *List:* ______________	☐	☐
3. **Do you have any on-going medical conditions *(i.e. seizures, diabetes, asthma, ADHD)?*** *List:* ______________	☐	☐
4. **Do you cough,wheeze or have difficulty breathing DURING or IMMEDIATELY AFTER exercise?** *List:* ______________	☐	☐
5. **Have you ever had surgery or been hospitalized overnight ?** *If YES explain* ______________	☐	☐
6. **Have you ever passed out or nearly passed out DURING exercise?** *If YES explain:* ______________	☐	☐
7. **Have you ever had pain/discomfort or pressure in your chest DURING exercise?** *If YES explain:* ______________	☐	☐
8. **Has a doctor ever told you that you have a heart murmur, heart problem, high blood pressure, high cholesterol or a heart infection?** *List:* ______________	☐	☐
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?** *If YES explain:* ______________	☐	☐
10. **Has a doctor ever ordered a test for your heart (i.e. echo, stress test)?** *Type of test* ________ *When:* ________	☐	☐
11. **Does anyone in your family have Marfan's syndrome,hypertrophic cardiomyopathy, long QTsyndrome,or other cardiomyopathy?** *If YES explain:* ______________	☐	☐
12. **Were you born without or are you missing a kidney, eye, testicle or any other organ?** *List:* ______________	☐	☐
13. **Have you ever had a concussion or serious head injury?** *If YES explain:* ______________	☐	☐
14. **Have you ever been hit in the head and been confused, lost your memory after the injury or been unable to move your arms or legs or felt weak?** *If YES explain:* ______________	☐	☐

____
Parent's Signature

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Exam: ______________

Body Mass Index: ___ ___ . ___

Weight Status Category (BMI Percentile)

Less than 5th ☐	5th thru 49th ☐	50th thru 84th ☐
85th thru 94th ☐	95th thru 98th ☐	99th and higher ☐

Height __________ Weight __________

Blood Pressure __________ Pulse __________

Skin ______________

EENT ______________

Neck / Thyroid ______________

Cardiovascular ______________

Lungs ______________

Abdomen ______________

Genitalia (Tanner Stage) ________ /LNMP________

Orthopedic: Structual 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) __________ Disease __________
MMR ______________
MEASLES ________ MUMPS ________ RUBELLA ________
MENINGITIS VACCINE ______________
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

revised 1/09