**PHYSICAN'S HEALTH APPRAISAL**
**CHAPPAQUA CENTRAL SCHOOL DISTRICT**
**Seven Bridges Middle School**

Name: ___________________________________________ Date: __________________
Address: __________________________________________ Grade entering (or as of 9/1/)________
Telephone #_________________________ Date of Birth ____________________
Physician's Name__________________________________Physician's Telephone #_______________________

List the specific sports in which your child will be participating for each season:
Fall _____________________ Winter _____________________ Spring ____________________

**I. Past Medical History** (to be completed by physician or parent/guardian)

| | Yes | No | Dates/details |
|---|---|---|---|
| Hospitalizations | | | |
| Operations/Surgery | | | |
| Daily Medications | | | |
| Allergies | | | |
| Significant Illnesses and/or Injuries | | | |
| Current conditions being monitored by a physician | | | |

**II. Additional History *Required for Sports Participation*** (to be completed by parent/guardian)

| | Yes | No | Dates/details |
|---|---|---|---|
| Ever denied full athletic participation? | | | |
| Absence of a paired organ | | | |
| Anemia | | | |
| Asthma/respiratory disorder | | | |
| Concussion (Number____) | | | |
| Frequent or Severe Headaches | | | |
| Fainting/passing out | | | |
| Heat exhaustion/heat stroke | | | |
| Heart disease- student | | | |
| Heart disease- family | | | |
| Hypertension | | | |
| Mononucleosis | | | |
| Seizures/epilepsy | | | |
| Describe any major musculo-skeletal injury or problem that occurred in the last 3 years | | | |

**III. Parent/Guardian Attestation (***For All Sports Participation)*
I declare that the above information is an accurate and true reflection of my child's condition.
Parent/guardian Signature____________________________________________ Date ____________________

**IV. Parent/Guardian Permission (***For In-School Sports Physicals Only)*
I give permission for the Chappaqua District Medical Team to perform the Pre-sports Evaluation.
Parent/Guardian Signature____________________________________________ Date ____________________

**V. Physical Examination**

Height:________ Weight:________

*Required for Sports Clearance*: Pulse ______________ BP ______________

| | Normal | Other (Specify) |
|---|---|---|
| Skin | | |
| Lymph Nodes | | |
| HEENT | | |
| Lungs | | |
| Heart | | |
| Abdomen | | |
| Genitourinary | | |
| Extremities | | |
| Orthopedic | | |
| Scoliosis | | |
| Neurologic | | |

**VI. Orthopedic Examination** (*required for sports*)

| | Normal | Other (Specify) |
|---|---|---|
| Neck | | |
| Back | | |
| Shoulder | | |
| Upper extremities | | |
| Lower extremities | | |
| Hamstrings. Finger-tip distance from floor:__________inches | | |

**VII. Testing, Laboratory and Immunizations**

Vision: L __________ R __________ Hearing: L _________ R___________

Laboratory: ________________________________________________________ Last Tetanus____________

**VIII. Summary**

Emotional Status: ? Well ? Other. Specify: ________________________________________________

Physical Assessment: ? Well ? Other. Specify: ________________________________________________

Physical Education: ? Permitted ? Restrictions. Specify: __________________________________________

*Sports participation*: ? Permitted ? Restrictions. Specify: __________________________________________

**IX. Examining Physician**

Signature: ______________________________________ Stamp:______________________________________

Phone: _________________________________________ Date of Exam:________________________________

**X.** ***For Sports Clearance Only***

Chappaqua Central Schools Medical Director Review ________________________________ Date__________