

**PHYSICIAN'S HEALTH APPRAISAL
CHAPPAQUA CENTRAL SCHOOL DISTRICT
Robert E. Bell 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 _____