

HEALTH HISTORY

Parent Section

CHAPPAQUA CENTRAL SCHOOL DISTRICT

Name: _____ Date: _____

Address: _____ Grade entering (as of Sept): _____

Home Phone: () _____ Cell / Contact Phone: () _____ Date of Birth: _____

School Attending: HGHS Seven Bridges Robert E. Bell

List the specific sports in which you child will be participating for each season:

Fall _____ Winter _____ Spring _____

Required 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			

Required for Sports Participation: Additional History (to be completed by physician or 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			

Parent / Guardian Attestation (For All Sports Participation)

I declare that the above information in an accurate and true reflection of my child's condition.

Parent / Guardian Signature _____ Date: _____

PHYSICIAN'S HEALTH APPRAISAL FORM

Chappaqua Central School District

Name: _____ Date of Birth: _____ Gender: M F
School: _____ Grade: _____ Home Phone: _____
Work Phone: () _____ Cell / Contact Phone: () _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
TB testing: Low Risk / not indicated PPD Date: _____ Positive Negative
SIGNIFICANT MEDICAL / SURGICAL HISTORY: None See attached Other (specify below)

Allergies: No Yes If yes: Food Insect Latex Medication Other: _____
Specify: _____
 LIFE THREATENING **Specify:** _____ Benadryl prescribed EpiPen prescribed
Medication Administration forms for Benadryl and EpiPen must be completed by physician and attached.

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Body Mass Index (Required): _____ . _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> < 5 th <input type="checkbox"/> 5 th to 49 th <input type="checkbox"/> 50 th to 84 th <input type="checkbox"/> 85 th to 94 th <input type="checkbox"/> 95 th to 98 th <input type="checkbox"/> >99 th	Vision: without glasses / contact lenses	R	L	<i>Referral</i>
	Vision: with glasses / contact lenses	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I II III IV V Scoliosis: Negative Positive _____
Specify any abnormality: _____

MEDICATIONS

Medications (list below): None
1. _____ 3. _____
2. _____ 4. _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND

Full participation in all physical education, sports, playground, work & school activities
 Limited participation Specify: _____

Physician's Signature: _____ **Date of exam:** _____
Provider's Name/Address: _____ **Phone:** () _____

Provider's Stamp: (required)