**WEST ISLIP PUBLIC SCHOOLS**
**MEDICAL EXAMINATION FORM**
**SHOULD BE RETURNED TO THE**
**BUILDING SCHOOL NURSE**

## FAMILY PHYSICIAN REPORT

NAME _____ DATE OF EXAM _____
DATE OF BIRTH_____ GRADE _____
HGT/WGT_____ HEART _____
EYE _____ LUNGS _____
EARS (OTISCOPE) _____ _ HERNIA _____
LYMPH NODES _____ GENITO-URINARY _____
THYROID _____ SCOLIOSIS _____
NOSE _____ TONSILS _____
TEETH _____ SKIN _____
NERVOUS SYSTEM _____ SEIZURE DISORDER _____
NUTRITION _____ SPEECH _____
BLOOD PRESSURE _____ ALLERGIES_____
TUBERCULIN TEST DATE _____ RESULTS _____
DATES OF IMMUNIZATIONS:
POLIO (IPV) _____ _____ _____ _____
DtaP _____ _____ _____ _____
Tdap _____
MMR _____ _____
HEP A _____ _____
HEP B _____ _____ _____
MENACTRA_____
VARIVAX OR HISTORY OF DISEASE _____
RECOMMENDATION: FULL ACTIVITY/SPORTS _____
MODIFIED ACTIVITY _____

(FOR MIDDLE AND HIGH SCHOOL STUDENTS ONLY)
SPORTS CATEGORIES: Clearance for sports participation in the following categories is approved as follows for the school year 20__ to 20__ (please initial all that applies):

____ CONTACT/COLLISION (Field Hockey, Football, Ice Hockey, Lacrosse, Soccer, Wrestling)
____ LIMITED CONTACT/IMPACT (Baseball, Basketball, Diving, Gymnastics, Handball, Skiing, Softball, Volleyball, Fencing)
____ STRENUOUS NON-CONTACT (Cross Country, Track & Field, Swimming, Tennis, Badminton, Cheerleading, Kickline/Dance, Weight Training)
____ NON-STRENUOUS/NON-CONTACT (Bowling, Golf, Archery, Riflery)

For unmarked categories, state reasons and provide medical conditions below.
_____
_____

☐ Further Evaluation/Consultation Needed From Private Physician Prior to Clearance.

**BODY MASS INDEX_____**
**WEIGHT STATUS CATEGORY (BMI PERCENTILE)**

**_____LESS THAN 5TH _____5TH-49TH_____50TH-84TH_____85TH-94TH_____95TH-98TH____99TH & ABOVE**

PHYSICIAN INFORMATION: Name of Physician (Print/Type/Stamp) _____
Address_____
Phone _____ Signature of Physician _____ Date _____