Somers High School • 120 Primrose Street Lincolndale, NY 10540
Health Office Phone: (914) 248-8612 Fax: (914) 277-2451

HEALTH CERTIFICATE / PHYSICAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached TB Testing ❒ Low Risk/Not indicated PPD: ❒ Positive ❒Negative Date: _____
❒ No immunizations given today Dental Referral ❒ Yes ❒ No ❒ Not done Date: _____
❒ Immunizations given since last Health Appraisal:

Significant Medical/Surgical History: ❒ None ❒ See attached ❒ Other (specify below) _____

_____

_____

Allergies: ❒ **No** ❒ **Yes** ❒Latex ❒ Food: _____ ❒ Insect: _____ ❒ Medication: _____
❒ Seasonal ❒ Other: _____
❒ **LIFE THREATENING Specify** _____ ❒ Benadryl Prescribed ❒ Epi Pen Prescribed

MEDICATION ADMINISTRATION FORMS FOR BENADRYL AND EPI PEN MUST BE COMPLETED BY PHYSICIAN AND ATTACHED.

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse _____ Date of Exam: _____

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: _____
Specify any abnormality (use reverse of form if needed): _____

_____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities**
❒ **Limited Participation Specify**_____
❒ **Specify medical accommodations needed for school**: _____ ❒ None

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

I give permission to Somers High School to exchange information with my child's physician when his/her care warrants.

Parent Signature: _____ Date: _____

REV 2012

SOMERS CENTRAL SCHOOL DISTRICT,
ATHLETIC DEPARTMENT, P.O. BOX 640 Lincolndale, NY 10540 (914)248-7315
Health Office Fax (914)277-2451

SPORTS CANDIDATE HEALTH HISTORY

Athlete's Name: _____School: _____Date of Birth___/____/____Grade_____

***I have reviewed the NYPHSAAS Student/Parent Information Sheet regarding concussions at http://www.nysphsaa.org/safety/pdf/StudentParentConcussionInformation.pdf Parent's Initials_____**

Has your child ever had: (please check)

	Yes	Date	No		Yes	Date	No
Allergies (Please Specify):				Headaches / Migraines			
				Head Injury / Concussion #			
Asthma				Nose Bleeds Frequent / Severe			
Anemia (including Sickle Cell)				Heart Problems: Murmur-Chest Pains			
Arthritis				Elevated Blood Pressure			
Bladder/Kidney Problem				Diabetes I / II			
Convulsions / Seizures				Injury to spleen / Mononucleosis			
Ear Problems / Hearing Loss				Fainting Spells / Heat Exhaustion			
Eye Problems / Vision Loss							
Is your child assigned to the Adaptive Physical Education Program, or has he/she ever been in an Adaptive Physical Education Program?							

If you answered yes to any of the above please explain in details, you may use the back of this form if necessary _____

_____

Describe any major muscular-skeletal injury or problem that occurred in the last 3 years: _____

_____

Does your child have any of the following? (Please circle)

Has your child ever had a condition which required hospitalization / surgery? YES NO
If Yes, Explain: _____

Does your child have a current medical condition which is being monitored by a physician? YES NO
If Yes, Explain: _____

Is your child taking any medication now? YES NO
If Yes, Explain: _____

Has there ever been a sudden death in a family member under 50 years of age? YES NO
If Yes, Explain: _____

Do you have any worries about your child's health or other questions you would like to discuss with a Doctor? YES NO

Does your child have orthodontic appliances / capped teeth? YES NO

Does your child wear contact lenses / glasses for sports? YES NO

Since your child's last physical examination, has he/she had any injury or medical illness? YES NO
If Yes, Explain: _____

PLEASE CIRCLE ONLY ONE SPORT PER SEASON

A NEW HEALTH HISTORY FORM WILL BE NEEDED 30 DAYS PRIOR TO THE START OF EACH SEASON

FALL-GIRLS	FALL-BOYS	WINTER-GIRLS	WINTER-BOYS	SPRING-GIRLS	SPRING-BOYS
Cheerleading	Cross Country	Basketball	Basketball	Lacrosse	Baseball
Cross Country	Football	Cheerleading	Gymnastics	Golf	Lacrosse
Field Hockey	Soccer	Gymnastics	Ice Hockey	Softball	Golf
Soccer		Skiing	Skiing	Track & Field	Tennis
Swimming		Track	Swimming		Track & Field
Tennis			Track		
Volleyball			Wrestling		

*** Your child will need a new Health History form 30 days prior to the start of each season.**

MEDICAL CLEARANCE MAY BE REQUIRED FOR NEW OR EXISITING CONDITIONS

Inherent in athletic participation is the possibility of minor injury, and in the extreme, severe injury and even death. It is understood that Somers School District will provide proper equipment and training, as well as safe facilities, in order to minimize these risks. By my signature below, I agree to let the coach, trainer and/or administration administer proper first aid, contact emergency medical services if deemed necessary, and to contact me at the earliest opportunity.

Parents Signature: _____ Parents Phone #: _____ Date: _____/_____/_____

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