

White Plains Public Schools
PRIVATE PHYSICIAN SPORTS PHYSICAL EXAMINATION FORM

****NO OTHER FORMS WILL BE ACCEPTED****

STUDENTS: SUBMIT TO SCHOOL NURSE 2 WEEKS PRIOR TO START OF PRACTICE

NAME _____ DOB _____ SCHOOL _____

DATE OF EXAM _____ DATE TO NURSE _____ SPORT _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R-20/ _____ L-20/ _____ Corrected _____ Uncorrected _____ Pupils _____

	Normal	Abnormal				
Cardiopulmonary						
Pulse						
Heart						
Tanner Stage	1	2	3	4	5	
Skin						
Abdominal						
Genitalia						
Musculoskeletal						
Neck						
Shoulder						
Elbow						
Wrist						
Hand						
Back						
Knee						
Ankle						
Foot						
Other						

Asthma or Reactive Airway Disease? Yes ___ No ___ *If yes:* Inhaler needed? Yes ___ No ___
 Before exercise/ practice/ games? (circle) Self administered? Yes ___ No ___

MEDICATIONS (Name and dose): _____

Clearance to participate: **PLEASE CIRCLE ONE**

- A. Cleared
- B. Cleared after completing evaluation/ rehabilitation for: _____
- C. Not cleared for: _____ Contact/Collision
 _____ Limited Contact/Impact
 _____ Non-Contact _____ Strenuous _____ Non-Strenuous

Due To: _____

Recommendation: _____

Private Physician Name/Stamp: _____ Address: _____

Private Physician Signature: _____ Phone: _____

School Physician's Signature for final approval: _____ Date _____

**White Plains Public Schools
INTERSCHOLASTIC SPORTS MEDICAL WAIVER**

PARENT/GUARDIAN PLEASE COMPLETE BEFORE STUDENT'S PHYSICAL
DO NOT USE PENCIL

STUDENT NAME _____ DATE _____

SPORT _____ GRADE _____ SCHOOL _____

PLEASE ANSWER YES OR NO TO ALL QUESTIONS. IF YES ANSWER, PLEASE EXPLAIN

Within the past 12 months, has the student had any problems requiring medical attention such as:

Illness lasting more than 5 days? _____ Disease? _____ Injury? _____ Surgery? _____ Hospitalization? _____
Mono? _____ Orthopedic problems/ Fractures? _____ Head Injury? _____ If yes, explain _____

Serious disease, injury to, loss or absence of an organ? Loss of vision in one eye? Yes _____ No _____

Does the student have **Asthma or Reactive Airway Disease?** Yes _____ No _____

Severely **Allergic** to medication, insect stings OR food? _____ Yes _____ No _____

History of heat intolerance, fainting, dizziness or **seizure disorder?** Yes _____ No _____
If yes, explain _____

History of passing out, dizziness or shortness of breath while exercising? Yes _____ No _____
If yes, explain _____

History of **heart problems-murmurs, extra beats or high blood pressure?** Explain _____ Yes _____ No _____

Has any member of the family had a sudden death or heart attack before age 50? Yes _____ No _____
If yes, explain _____

Does the student have diabetes? Yes _____ No _____

Any disabilities or chronic illnesses? Yes _____ No _____
If yes, explain _____

Has the student ever been disqualified from sports participation due to a medical problem? Yes _____ No _____
If yes, explain _____

Is the student currently taking **Any** medications? Yes _____ No _____
Please list, including inhalers _____

Does the student need to carry medication with her/him? Yes _____ No _____
Date of last tetanus booster. _____

My son/ daughter presently wears: Braces Yes _____ No _____
Eyeglasses Yes _____ No _____
Contact lenses Yes _____ No _____
Removable Dental appliance Yes _____ No _____

I TAKE FULL RESPONSIBILITY FOR THEIR USE DURING SPORTS PARTICIPATION. Yes _____ No _____

MY SON/DAUGHTER HAS MY PERMISSION TO PARTICIPATE IN THE ABOVE NAMED SPORT

Parent/Guardian Signature _____ Date _____