

Martin Luther School

Small School.  Smart Choice.

60-02 Maspeth Avenue Maspeth, NY 11378 | 718.894.4000 | www.MartinLutherNYC.org

Middle School 6-8 | High School 9-12

ATHLETIC DEPARTMENT ANNUAL PHYSICAL EXAMINATION

Name _____ Date of Birth ____/____/____ Grade _____

Parental Permission I have reviewed the students Medical History and I give permission for _____ to have physical exam. _____

Signature _____

Date ____/____/____

Relationship _____

ALL INFORMATION IN THIS BOX MUST BE COMPLETED BY THE PHYSICIAN:

Height _____ Weight _____ B. M. I. : _____ . _____

Blood Pressure _____

Weight Status Category (BMI Percentile):

less than 5th 5th through 49th 50th through 84th

85th through 94th 95th through 98th 99th and higher

Scoliosis () Negative () Positive

Vision: (L) _____ (R) _____ Hearing: (L) _____ (R) _____

Allergies: _____

Known Medical Conditions: _____

Restrictions _____

SYSTEM REVIEW & PHYSICAL EXAM: LEAVE BLANK IF NORMAL – NOTE ANY DEFECTS

Cardiovascular _____

Respiratory _____

Musculoskeletal _____

Past injuries _____

Nervous _____

Digestive _____

Genito-Urinary _____

Endocrine _____

Integumentary _____

ENT _____

IMMUNIZATIONS GIVEN TODAY _____

IMMUNIZATIONS COMPLETED/UPDATE _____

MEDICATIONS: _____

Medications during school day: _____

The Above student is medically cleared for all school activities, physical education, interscholastic sports and job requirements. Please note any restrictions: _____

Date ____/____/____

PLEASE STAMP

Address _____

Phone Number _____

Examiner's Signature _____

Registry Number _____

HEALTH UPDATE: It is the sole responsibility of the parent and/or guardian to furnish the athletic department with information regarding any change in health status prior to the start a new sports season.

SPORTS CANDIDATE QUESTIONNAIRE

NAME _____ DOB ___/___/___ GRADE _____ ACTIVITY _____

PARENT/GUARDIAN: Answer the following questions as accurately as possible. Please give specific details.

1. Has student suffered any head injuries/concussions with or without loss of consciousness during his/her lifetime? Yes/No When? _____
Did loss of consciousness occur? Yes/No

Describe event _____

2. Any broken bones, fractures, surgery? Yes/No When? _____
Describe _____

3. Any other injury requiring medical attention/hospital visit? Yes/No When? _____

Describe _____

4. History of heart murmur? Cardiac Arrhythmia? Palpitations? Yes/No Describe _____

5. Asthmatic? Yes/No Requires an inhaler for sports/exercise? Yes/No Describe _____

6. Any other chronic diseases or ailments? Yes/No Describe _____

7. Any fainting/dizziness/fatigue after exertion? Yes/No Describe _____

8. Taking medications at this time? Yes/No Describe _____

9. Allergies? Yes/No Describe _____

10. Glasses or contact lenses: Yes/No Protective eyewear needed? Yes/No

11. Date of last Tetanus shot ___/___/___ (must be within 10 years)

12. Date of last physical ___/___/___

****IMPORTANT**** Do you know of any reason that your child cannot participate in any sport/activity? Yes/No

Describe _____

HEALTH RECORD INFORMATION

We understand clearly that the questions are asked in order to decide if this student is in proper condition to participate in the athletic sport/activity named at the top of this form. The answers will be kept confidentially in his/her health record in the school /athletic office.

_____ / ___ / _____ / ___ / _____
PARENT/GUARDIAN SIGNATURE DATE STUDENT SIGNATURE DATE