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

_____
Examiner's Signature

_____ _____ _____
Address **Phone Number** **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