Health Appraisal/Sports

(use black ink only)

To be completed by PHYSICIAN ONLY

Kenmore-Town of Tonawanda UFSD
Student Services / Health Services

Name of Student _____

IMMUNIZATIONS / SCREENINGS
(Check one and record below)
☐ No immunizations /screenings given today
☐ Given since last exam
☐ Record attached

Dates and vaccines given within the last year:

_____
_____
_____
_____

Vision/Hearing

Vision without:	☐ glasses ☐ contact lenses	**R**	**L**
Vision with:	☐ glasses ☐ contact lenses	**R**	**L**
Vision:	Near Point	**R**	**L**
Hearing:	☐ Screening ☐ Audiogram	**R**	**L**
	Tympanogram	**R**	**L**

MEDICAL HISTORY
Significant medical/ surgical history: _____
Allergies: _____
Medications taken regularly: _____

PHYSICAL EXAMINATION
Height: _____ Weight: _____ BP: _____ / _____ Resting Pulse: _____ Fe LMP: _____

	Normal	Abnormal		Normal	Abnormal
General appearance			Neck: nodes/thyroid		
Nutrition			Lungs		
Skin			Heart		
Head			Abdomen		
Eyes			Genitalia		
Ears			Musculoskeletal		
Nose/Throat			Scoliosis	☐ Neg	☐ Pos
Teeth			Neurological		

Comments
Scale 1-5: 1=Cachetic 3=WNL 5=Obese

BMI: **BMI %:**

Tanner Stage – Must be completed for student to play sport
☐ I ☐ II ☐ III ☐ IV ☐ V

☐ No Medication ☐ Medication at home only ☐ Medication to be given at school

Name, route, dosage, frequency, time: _____

If morning does is missed at home: _____

Missing organs: Eye, Kidney, Gonad

Student is "self-directed" ☐ Yes ☐ No
Student may carry MDI: ☐ In school ☐ On Field Trips

***Self-directed**: Student knows use and purpose of medication, route, dosage, and frequency of administration.*
Student is capable of self-administration of medication with adult supervision; may carry MDI.

Parent/Guardian name (print) _____ Parent/Guardian signature _____

SPORTS: Student is physically qualified for participation in sports and school activities as indicated below:
☐ Contact/Collision: Baseball, Basketball, Diving, Field hockey, Football, Ice hockey, Jumping, Lacrosse, Soccer, Softball, Wrestling
☐ Non-Contact/Strenuous: Cheerleading, Cross-country, Field hockey, Gymnastics, Running, Track & Field, Volleyball, Swimming
☐ Non-Strenuous: Bowling, Golf, Rifle
☐ Knowledge-based experience only

Protective Equipment: ☐ Athletic cup ☐ Chest pad ☐ Glasses/ eye wear ☐ Helmet ☐ Joint pads ☐ Mouth guard ☐ Wrist guards

EMPLOYMENT: ☐ Student is physically qualified for employment ☐ Known or suspected disability: _____
☐ Restrictions _____

Provider name (please print) _____ Telephone # _____ Fax # _____

Provider signature _____
Date of exam _____

Health History

Parents must complete this side

Kenmore-Town of Tonawanda UFSD
1500 Colvin Boulevard
Buffalo, NY 14223

Name of Student _____ Age _____ Date of Birth _____

Sport _____ School _____ Gender _____ Grade _____

*** For the students completing a sport physical:**
The Health History and Health Appraisal (reverse side) must be completes within 12 months **BEFORE** sports participation and tryouts. (The Health History must be completed before the student has his/her physical).
Students **MUST** pick up and return **ALL** forms to the Health Office.
DO NOT TURN INTO THE COACH.

Part A – Health History: To be completed by Parent/Guardian.

Has your child ever had, or currently has, any of the following: (please check) *Fill in below if YES.

	Yes	No	Date
1. Elevated blood pressure	☐	☐	_____
2. Heart Problem/Murmur/chest pains	☐	☐	_____
3. Allergies/hay fever (type) _____	☐	☐	_____
4. Insect sting allergy (type) _____	☐	☐	_____
5. Asthma	☐	☐	_____
6. Diabetes/hypoglycemia	☐	☐	_____
7. Injury to spleen	☐	☐	_____
8. Heat exhaustion/stroke, other	☐	☐	_____
9. Joint sprains/ligament tear, muscle	☐	☐	_____

	Yes	No	Date
10. Back problem	☐	☐	_____
11. Knee problem	☐	☐	_____
12. Ankle problem	☐	☐	_____
13. Headaches/dizziness	☐	☐	_____
14. Head injury/concussion	☐	☐	_____
15. Loss of consciousness due to injury	☐	☐	_____
16. Neck injury	☐	☐	_____
17. Convulsions/seizures	☐	☐	_____
18. Hernia	☐	☐	_____

	Yes	No	Date
1. Within the last 12 months has your child had an illness that:			
a. required hospitalization?	☐	☐	_____
b. lasted longer than a week?	☐	☐	_____
c. caused missing 5 days of practice or competition?	☐	☐	_____
d. required surgery for (explain) _____	☐	☐	_____
2. Within the last 12 months has your child had an injury that:			
a. required going to the emergency room or to see a doctor?	☐	☐	_____
b. required hospitalization?	☐	☐	_____
c. required x-rays?	☐	☐	_____
d. caused missing 5 days of practice?	☐	☐	_____

	Yes	No	Date
3. Does your child take any medication now?	☐	☐	_____
(list) _____			
Any long term medications?	☐	☐	_____
list) _____			
4. Does your child wear (circle which)			
a. glasses/contacts	☐	☐	_____
b. dental bridges, plates/braces, special pads, protective equipment	☐	☐	_____
5. Is your child missing one of any paired organs? (circle one) eye, kidney, testicle, ovary	☐	☐	_____
6. Has there ever been sudden death in the family of a person under 50 yrs of age?	☐	☐	_____
(explain) _____			

7. FOR WOMEN: Fill in the following
a. Age at first menstrual period _____
b. How often period occurs _____
c. When was last period? _____

***YES ANSWERS MUST PROVIDE EXPLANATION FOR APPROVAL TO PARTICIPATE.** (Explain) _____

AFFIRMATION: I affirm that the preceding statements are true and correct, and I consent to the participation of my child in the interscholastic program of his/her school, including practice sessions and travel to-and-from the athletic contests; I agree to emergency medical treatment for my child, as deemed necessary by the physician designated by school authorities; I give my permission for the school nurse to share any pertinent health information regarding my child with school and emergency personnel on a need-to-know basis. Signature implies consent for school physical if needed.

Signature of Parent/Guardian: _____ Date: _____
Emergency Telephone: _____ Cell Phone: _____
Home Address: _____ Work Phone: _____
Private Physician: _____ Private Physician Telephone: _____

Update Athletic Health History for Sports Participation

Kenmore-Tonawanda UFSD
Department of Physical Ed./ Recreation/Athletics and Health Services
1500 Colvin Blvd. Buffalo, NY 14223

School ☐ KE ☐KW ☐FMS ☐HMS ☐KMS

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted, unless the student received a full medical examination within 30 days of the start of the season.

Please use black or blue ink only.

Name of Student _____ Grade _____ Date of Birth_____

Sport _____ Level: ☐ Varsity ☐ JV ☐ Frosh ☐ Modified

To be completed by Parent/Guardian

Note: "Yes" to any of the following questions does not mean automatic disqualification from the athletic activity indicated above. However, it will require a review and approval by the school examiner before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office, and will be kept confidential. Coaches will be informed of any significant medical information.

History Since Last health Appraisal

If the answer to any of the following questions is "yes", please describe the condition or situation that prompted your answer.

	Yes	No	Date
Has your child had any injuries requiring medical attention?	☐	☐	____
Has your child had any illness lasting more than five (5) consecutive days?	☐	☐	____
Is your child taking medicine or under a physician's care at this time?	☐	☐	____
Has your child experienced any feeling of faintness, dizziness or fatigue after exercise or exertion?	☐	☐	____
Has there been a change regarding the wearing of glasses or contact lenses?	☐	☐	____
Has your child had any surgical operations or fractures?	☐	☐	____
Has your child received treatment in a hospital or emergency room?	☐	☐	____
Has your child developed any allergies?	☐	☐	____
Does your child have any chronic disease?	☐	☐	____

(Use the space below to explain any "Yes" answers and give dates)

_____

_____

_____

Parental Permission

I, the undersigned, clearly understand that these questions are asked in order to decide if my child can safely participate on the athletic team named on this form. The answers are correct as of this date and he/she has my permission to participate.

Signature of Parent/Guardian: _____ Date: _____

Please fill in completely, sign, and return to School Health Office

NIAGARA FALLS
Memorial Medical Center
Niagara's Premier Health Network

KENMORE-TOWN OF TONAWANDA SCHOOLS ATHLETICS

UB MD ORTHOPAEDICS & SPORTS MED SINCE

Athlete's Name: _____ Date: _____

Athlete's Date of Birth: _____ Grade: _____

Athlete's School: _____ List Sport(s):

Fall: _____

Winter: _____

Spring: _____

Niagara Falls Memorial Medical Center partnered with UBMD Orthopaedics and Sports Medicine provides a staff certified athletic trainer (ATC) for the Kenmore-Tonawanda School District. This ATC is qualified to recognize, assess and rehabilitate most injuries your son or daughter may incur while participating in athletics as part of the Kenton School District.

The ATC's qualifications include: certification by National Athletic Trainer's Association's BOC, registration with the NYS Education Department, certification in CPR/AED and a minimum of a bachelor's degree in athletic training.

I give my permission for the ATC to recognize, assess and rehabilitate my son or daughter.

_____ _____

Parent/Guardian's Signature Printed Name

Address: _____ Evening Phone # (After 5pm): _____

_____ Daytime Phone #: _____

Please return to the school nurse or coach with completed physical card

Niagara Falls Memorial Medical Center 621 10th Street, Niagara Falls, NY 14302
Summit Healthplex Suite 600/700, UBMD Orthopaedics and Sports Medicine, 6934 Williams Road, Niagara Falls, NY 14304. Contact Phone Number: 716-215-0723