OYSTER BAY HIGH SCHOOL HEALTH ASSESSMENT FORM

NYSED requires an annual physical exam for new entrants, students in Grades K,2,4,7& 10, sports, working papers and triennially for the Committee on Special Education (CSE)

Date Of Exam__________________ Grade_________________

Name:____ Birth Date:____/____/_____ Age:______ Sex: ☐ M ☐ F

Allergies ☐ LIFE THREATENING ☐ Food: _______________________________ ☐ Insect: ________________________

☐ SEASONAL ☐ Medication: __________________________ ☐ Other: _________________________

Asthma: ☐ Yes ☐ No _________________________ Diabetes: ☐ Yes ☐ No _________________________________

Significant Medical/Surgical History ☐ Yes ☐ No If Yes Explain:____

____

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name:____Dosage/Time:_________________________________

Name:____Dosage/Time:_________________________________

I assess this student to be self directed ☐ Yes ☐ No Student may carry and self administer ☐ Yes ☐ No

Height:______________ Weight:___________ BMI: _________

☐ Less than 5%	☐ 5 thru 49%	☐ 50 thru 84 %
☐ 85 thru 94%	☐ 95 thru 98%	☐ 99% & greater

Blood Pressure:____________ Heart Rate:____________ Tanner: I. II. III. IV. V

Vision – without correction	R	L	Referral: ☐ Yes ☐ No
Vision – with correction	R	L	
Hearing	R	L	Referral : ☐ Yes ☐ No
Scoliosis	☐ Pass	☐ Fail	Findings:

Concussion History ☐ YES ☐ NO Explain:____

☐ NORMAL EXAM Specify any abnormalities (use reverse if needed):_______________________________________

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☐ Free from contagions & physically qualified for all physical education, sports, work & school activities as checked ANY UNMARKED CATAGORIES INDICATES DISQUALIFICATION

☐ CONTACT/COLLISION	☐ LIMITED CONTACT	☐ STRENUOUS	☐ NON-STRENOUS
Field Hockey Football Lacrosse Soccer Wrestling	Baseball /Softball Fencing / Handball Volleyball Basketball	Cross Country / Track Tennis Cheerleading Badminton	Bowling Golf

☐ Restrictions:____

☐ Medical accommodations needed for school:____

Provider's Signature: ____ Phone _____________________________

Provider's Name/Address: ____Fax::______________________________

This exam complies with NYSED and is valid for TWELVE MONTHS, with the exception of any illness or injury lasting more than 5 days that will require review by private healthcare provider/school medical director.