West Islip Public Schools

The Michael & Christine Freyer Administration Building
100 Sherman Avenue, West Islip, NY 11795
Tel: (631) 930-1540 Fax: (631) 930-1567

Richard A. Simon
Superintendent of Schools

Tim Horan
Director of Athletics, Physical
Education, Health & Recreation

INTERSCHOLASTIC SPORTS PROGRAM

January, 2012

Dear Parent:

The New York State Education Law requires that all students participating in interscholastic sports must have a physical examination.

West Islip School District is mandating student athletes to obtain their own sports physical from private physicians. All physicians who administer a physical are required to complete the form provided by the school district. Students are to return the completed form to the nurse's office of their respective school upon completion of the physical. Sport sign-ups are conducted in physical education classes prior to the season.

1. Must use attached physician's form.

2. The physical will be at the expense of the parent.

3. Upon completion of the physical, return the completed form to the school nurse's office of your respective school.

4. Student medical history (blue card) must be completed by parent/guardian and signed. **Blue cards are issued when physical exams have been completed.**

Sport physicals are valid for one year.

Sincerely,

Tim Horan

TH/pp

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2012

Dear Physician:

West Islip School District is mandating student athletes to obtain their own sports physical from private physicians. All physicians who administer a physical are required to complete the forms provided by the School District. Students are to return completed form to the nurse's office of their respective school upon completion of the physical.

The following health problems and/or conditions require **a specific written notation by you** on the Sports Physical Certificate and/or a note from the appropriate specialist as indicated below:

1. Any cardiac condition, exclusive of murmurs, requires an annual clearance from a CARDIOLOGIST. All murmurs (prior or existing) require a clearance annually from a private physician or cardiologist as determined by the school physician.

2. All intracranial pathology, seizure disorders resultant from intracranial pathology, and all postneurological surgery require an annual clearance from a NEUROLOGIST/NEUROSURGEON. Idiopathic, stabilized epilepsy requires an annual clearance.

3. Any chronic illnesses (i.e. diabetes, hypertension, congenital anomalies, etc.) require an annual clearance.

4. All current orthopedic and/or surgical procedures require a clearance from the appropriate specialist.

5. All illness or accidents wherein a child is absent for 5 days or more (i.e. mononucleosis, hepatitis, etc.) require a clearance.

6. All right-sided varicoceles and hernias require a clearance.

7. Blood pressure exceeding 150/90 (systolic or diastolic) requires a clearance.

8. Proteinuria of 1+ or higher requires a clearance.

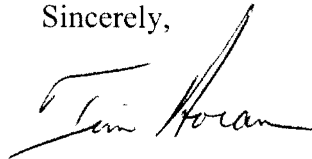
9. Any cancers in remission treated with chemotherapy require a clearance annually from the treating physician for five (5) years after THE LAST CHEMOTHERAPY PROTOCOL.

10. Any student with chronic, active asthma is required to produce a physician's clearance annually that must detail any medication currently in use. Any student with severe allergic reactions requiring emergency treatment (i.e. bee stings, wasp stings, etc.) requires a clearance and also requires that the parents provide the necessary means of treatment to the appropriate coach (i.e. Ana-kits, etc.). Clearance will depend upon the appropriate provision of such equipment.

ALL CLEARANCES MUST BE INDICATED CLEARLY ON THE PHYSICAL FORM

THE SCHOOL PHYSICIAN HAS THE FINAL AUTHORITY TO DETERMINE THE PHYSICAL CAPABILITY OF A STUDENT TO PARTICIPATE IN A SPORT.

Sincerely,



Tim Horan

TH/pp

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

HEALTH CERTIFICATE / APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

School: ______________________ **Gender:** ❑ M ❑ F **Grade:** ______________________

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ No immunizations given today
❒ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❒ Positive ❒Negative ❒ Not done Date: __________
PPD: ❒ Positive ❒Negative ❒ Not done Date: __________
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: __________
Dental Referral ❒ Yes ❒ No ❒ Not done Date: __________

Significant Medical/Surgical History: ❒ See attached ______________________

Allergies: ❒ **LIFE THREATENING** ❒ Food: __________ ❒ Insect: __________ ❒ Other: __________

❒ Seasonal ❒ Medication: ______________________

PHYSICAL EXAM

Height: __________ Weight: __________ Blood Pressure: __________ Date of Exam: __________

Body Mass Index: ___ ___ . ___ Weight Status Category (BMI Percentile): ❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th ❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher				Referral
	Vision - without glasses/contact lenses	R	L	
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: __________

Specify any abnormality (use reverse of form if needed): ______________________

MEDICATIONS

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

Name: ______________________ Dosage/Time: ______________________

Name: ______________________ Dosage/Time: ______________________

If AM dose is missed at home: ______________________

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: ______________________ ❒ None

❒ **Known or suspected disability:** ______________________ ❒ Please monitor

❒ **Restrictions:** ______________________ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Other: __________

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: ______________________

Provider's Signature: ______________________ Phone: __________ (Stamp below)

Provider's Name/Address: ______________________ Fax: __________

Parent Signature: ______________________ Date: __________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 2/08*