Garden City Public Schools

Medical Evaluation

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student's Name _____ **Male** ☐ **Female** ☐

Grade _____ **Teacher / Homeroom** _____ **Date of Birth:** _____

Address: _____ **Home Telephone:** _____

Physician to be called in emergency: _____ **Telephone:** _____

Parent or Guardian: _____ **Telephone/Cell:** _____

TO BE COMPLETED BY PARENT OR GUARDIAN

STUDENT'S HEALTH HISTORY

Please check YES or NO to the following questions, if you answer yes to any questions explain below.

Date _____

	YES	NO
1. Does your child have allergies? *List:* _____	☐	☐
2. Does your child take any daily medications? *List:* _____	☐	☐
3. Does your child have any on-going medical conditions *(i.e. seizures, diabetes, asthma, ADHD)?* *List:* _____	☐	☐
4. Does your child cough,wheeze or have difficulty breathing DURING or IMMEDIATELY AFTER exercise? *List:* _____	☐	☐
5. Has your child ever had surgery or been hospitalized overnight ? *If YES explain* _____	☐	☐
6. Has your child ever passed out or nearly passed out DURING exercise? *If YES explain:* _____	☐	☐
7. Has your child ever had pain/discomfort or pressure in their chest DURING exercise? *If YES explain:* _____	☐	☐
8. Has a doctor ever told you that your child has a heart murmur, heart problem, high blood pressure, high cholesterol or a heart infection? *List:* _____	☐	☐
9. Has any family member or relative died of a heart problem, heart attack, stroke or a sudden unexplained death before the age of 50? *If YES explain:* _____	☐	☐
10. Has a doctor ever ordered a test for your child's heart (i.e. echo, stress test)? *Type of test* _____ *When:* _____	☐	☐
11. Does anyone in your family have Marfan's syndrome,hypertrophic cardiomyopathy, long QTsyndrome,or other cardiomyopathy? *If YES explain:* _____	☐	☐
12. Was your child born without or is missing a kidney, eye, testicle or any other organ? *List:* _____	☐	☐
13. Has your child ever had a concussion or serious head injury? *If YES explain:* _____	☐	☐
14. Has your child ever been hit in the head and been been confused, lost memory after the injury or been unable to move arms or legs or felt weak? *If YES explain:* _____	☐	☐

* ***I give permission for the school physician to examine my child.*** YES ☐ NO ☐

_____

Parent's Signature

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Exam: _____

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile)

Less than 5th ☐ 5th thru 49th ☐ 50th thru 84th ☐

85th thru 94th ☐ 95th thru 98th ☐ 99th and higher ☐

Height _____ Weight _____

Blood Pressure _____ Pulse _____

Skin _____

EENT _____

Neck / Thyroid _____

Cardiovascular _____

Lungs _____

Abdomen _____

Genitalia (Tanner Stage) _____ /LNMP_____

Orthopedic: Structual Defect _____

Scoliosis _____

Nervous system _____

Do you approve this student for ALL Interscholastic Sports?

YES ☐ **NO** ☐

Reason for disqualification _____

_____

IMMUNIZATION UPDATE ONLY

DTaP _____

Tdap _____

DT/Td _____

IPV _____

HIB _____

HEP B _____

VARICELLA (Varivax) #1_____ #2_____

MMR #1_____ #2_____

MEASLES _____ MUMPS_____ RUBELLA _____

MENINGITIS (MCV4) #1 _____ #2 _____

OTHER VACCINE _____ date _____

OTHER VACCINE _____ date _____

BLOOD LEAD SCREENING _____

PPD: _____ Pos. _____ Neg. _____

_____

Health Care Provider's Signature

_____

Health Care Provider's Name (Please Print)

_____

Health Care Provider's Address

_____

Health Care Provider's Telephone

_____

School Physician's Signature

revised 10/16/16