Levittown Union Free School District
Annual Physical Examinations/Sports Participation Health History

Parents please complete the Health History and the parent permission form below. All questions must be completed and returned to the Health Office before a physical will be given for Athletics.

I hereby give my son/daughter _____ permission to participate in _____
(print student's name) (sport)
for the school year 20___/____.

Signature of Parent/Guardian:_____

Student Health History
(To be completed by parent/guardian)

Please check if the student has had any of the following:

_____	Asthma/Allergies	_____	High Blood Pressure
_____	Anemia	_____	Headaches
_____	Diabetes	_____	Heart Disease/Murmur
_____	Chronic Cough/TB	_____	Eye Injury/Loss
_____	Kidney Disease	_____	Rheumatic Fever/Joint Problem
_____	Prolonged Bleeding	_____	Concussion
_____	Jaundice	_____	Seizures
_____	Hearing Loss	_____	Neck, Back, Shoulder, Knee, Hip Pain

Any operation or serious injury _____Date_____

SINCE THE LAST PHYSICAL EXAM FOR ATHLETICS:

		YES	NO
1.	Any injuries requiring medical attention?	_____	_____
2.	Any illness lasting more than 5 days?	_____	_____
3.	Taking medication/under physician's care?	_____	_____
4.	Treated in hospital or emergency room?	_____	_____
5.	Head injury with or without loss of consciousness?	_____	_____
		_____	
6.	Surgical procedure or fracture?	_____	_____
7.	Any feeling of faintness, dizziness, or fatigue after heavy exertion?	_____	_____
8.	Any reason this student should not participate in sports?	_____	_____

If answering "yes" to any question above, please explain:_____

TO BE COMPLETED BY PHYSICIAN

Body Mass Index _____
Weight Status Category (BMI Percentile)

☐ Less than 5th ☐ 5th through 49th ☐ 50th through 85th

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

Height:_____ Weight: _____
Heart:_____ Lungs:_____
Blood Pressure:_____ Pulse:_____
Nose/Throat:_____ Abdominal:_____
Genitourinary_____

Eyes: R_____ L_____ Ears: R_____ L_____
Nervous System_____ Orthopedic_____ Scoliosis_____
Medication taken regularly:_____
Preventative measures given in the last year:_____

I certify that the above named student is physically qualified to participate in the Interscholastic Athletic programs checked below. Physician should initial the approved categories.

Contact Sports ( )		Endurance Sports ( )		Other Sports ( )
Baseball	Basketball	Cross Country	Track	Bowling
Football	Hockey (Ice/Field)	Gymnastics	Swimming	Golf
Lacrosse	Soccer	Tennis	Volleyball	Field Events
Wrestling	Softball	Other_____		Other_____
Other_____				

_____ _____ _____
Physician's Signature **Date** **Physician's Stamp**

May participate in all interscholastic sports with no restrictions:_____
May not participate in interscholastic sports pending:_____
May not participate in interscholastic sports due to:_____

_____ _____ _____
Physician's Signature **Date** **School Nurse's Signature**