

# SPORTS PHYSICAL

IN COMPUTER

**5<sup>th</sup>** – needed *only* if joining cross country sports

**7<sup>th</sup> + 8<sup>th</sup>** if joining *any interscholastic*

Middle School Phone: 708-246-3210

Middle School Fax: 708-352-0092

**Required only:** if participating in interscholastic sports

Dear Parents:

Students in 7<sup>th</sup> and 8<sup>th</sup> grade are eligible to participate in the interscholastic sports program offered at Pleasantdale School. As well as, **5<sup>th</sup> grade students participating in Cross Country**. State Board of Education rules require that any child participating in interscholastic sports must receive an annual physical examination prior to participating with the team. Because of the heavy load experienced by most doctors prior to the start of school, below is a combination parent permission and physician's form. Completed forms may be turned in at the school office during the summer or with registration. **Please remember, no child will be eligible to participate in any sport unless the completed form is signed by the parent, and physician, and the form is on file before 1<sup>st</sup> tryout/practice. A Parent/Guardian signature and PHYSICIAN SIGNATURE is required on this form.**

**“OVER THE COUNTER” Medications** approved for student (please checkmark each type for approval): **Physician Signature required**

- Acetaminophen (Tylenol)  Ibuprofen (Advil, Motrin)  Anti Diarrhea  Anti-itch (Calamine)  Antacids (Tums)  Advil / Tylenol Cold + Sinus  Excedrin
- Anbesol  Benadryl allergy tabs/(Spray for reaction)  Cough drops  Cold medication  Cough suppressant  Chloraseptic (Sore Throat Spray)  Decongestant
- Contact solution  Rewetting drops (contacts)  Eye Drops (Visine reg. or allergy)  Expectorant  Nasal Spray  Other \_\_\_\_\_
- I do not want any medications given to my child during school hours. I understand by checking this space that I am willing to come to school to administer medications as needed.

**Note - unless specified, dosage will be administered as per directions on medicine container**

I hereby give **(NAME)** permission to participate in interscholastic sports for the 20\_\_ to 20\_\_ school year, and ride a school bus to and from the sports activity. Such sports might include any or all of the following: Basketball, Volleyball, Soccer, Softball, Cross Country or Cheerleading. If for any medical or other reason your child is unable to participate in one or more sport(s), please list the sport and the reason why \_\_\_\_\_.

*TO BE COMPLETED BY PHYSICIAN/APN/PA (Indicating testing mandated for state licensed child care facilities or selected schools and programs)*

Evaluation: **Required**

**Strongly Recommended**

	Normal	Abnormal	Follow-up comments		Date	Results/Normal	Abnormal Result
Height				Hemoglobin* or			
Weight				Hematocrit *			
Skin				Urinalysis			
Eyes				Sickle Cell *as needed			
Ears				Nutritional Status			
Nose				Gastrointestinal			
Throat				Genito-urinary			
Mouth/Dental				Neurological			
Cardiovascular/HTN				Muscular Skeletal			
Respiratory				Scoliosis Screening			
<b>Allergies</b> (food, drug, insect)				<b>Medication</b> (list all prescribed or taken on a regular basis)			
<b>Needs/Modifications</b> required in the school setting				Dietary			
<b>Special Instructions/Devices</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic cup							
<b>Lead Questionnaire *</b> Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No Blood test indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No Blood test Performed <input type="checkbox"/> Yes <input type="checkbox"/> No							
TB Skin Test Recommended only for children in high-risk group; includes children who are immunosuppressed d/t HIV infection or other countries, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines Date Read / / Results mm.							
Mental Health/Other: Is there anything else that you think the school should know about this student?							
If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal							
EMERGENCY ACTION needed while at school d/t child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:							
On the basis of the examination on this day, I approve this child's participation: (If No or Modified, please attach explanation.)							
<b>Physical Education</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified				<b>Interscholastic Sports (for one year)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited			

X

\_\_\_\_\_  
Physician Signature + Date (required)

X

\_\_\_\_\_  
Parent Signature + date (required)