Top part must be filled out and signed. . .

DEPARTMENT OF HEALTH * THE CITY OF NEW YORK * BOARD OF EDUCATION
INTERSCHOLASTIC * SPORTS EXAMINATION * - CONFIDENTIAL

Regulation of the Chancellor

PART I to be filed in Student's Health folder

OSIS # _____ I.D. # _____
NAME: _____ SCHOOL: _____ BOROUGH: _____
ADDRESS: _____ HOMEROOM: _____ GRADE: _____
_____ DATE OF BIRTH: _____
TELEPHONE: _____ EMERGENCY TELEPHONE: _____
SPORT: _____
SPORT: _____

PARENTAL PERMISSION: I have reviewed the **STUDENT MEDICAL HISTORY** section below and I agree with the answers. I give permission for _____ to have a physical examination. I understand that completion of the Maturation Index is optional.

DATE: _____ SIGNATURE: _____
********** RELATIONSHIP: _____
****

CLINICIAN'S RECOMMENDATIONS

Based on my review of the history and physical examination as noted below and on the back of this form, and review of the guidelines for this student:

(1) May participate in the following sports:
DRAW A LINE TRHOUGH ANY SPORTS TO BE OMITTED:

CONTACT	ENDURANCE	OTHER
Football	Gymnastics	Bowling
Baseball	Swimming	Golf
Basketball	Track & Field	Crew
Soccer	Cross-country	Cheerleading
Hockey	Tennis	Field Events
Wrestling	Volleyball	Archery
Lacrosse	Handball	
Softball	Fencing	
Cricket	Double Dutch	
Rugby		

DATE OF LAST TETANUS BOOSTER: _____

(2) Special conditions for participation (e.g., pre-exercise medication or protective equipment), if any:

DATE: _____ SIGNATURE: _____ (CLINICIAN)
TELEPHONE: _____ NAME: (PRINT) _____
REGISTRY #: _____ ADDRESS: _____
_____

Doctor Stamp + Signature Required.

Fill in All info

STUDENT'S MEDICAL HISTORY

(To be filled out by student and parent) Clinician's Comments

Has anyone in your family under age 45 died suddenly	Yes ___ No ___
Have you ever had:	
Concussion or been knocked out?	Yes ___ No ___
Fainting?	Yes ___ No ___
Heat Stroke?	Yes ___ No ___
Epilepsy, seizures, or fits?	Yes ___ No ___
Head or neck injury?	Yes ___ No ___
Very bad vision in one or both eyes?	Yes ___ No ___