CHRIST THE KING HIGH SCHOOL
68-02 METROPOLITAN AVENUE • MIDDLE VILLAGE, NEW YORK 11379

The student's physical exam must be performed by a licensed physician.
This form MUST be returned to the school medical office.

SECTION "A": TO BE COMPLETED BY PARENT OR GUARDIAN **Graduating Year_____**

Student's Name: _____ Sex: M_____ F_____
Last First Middle

Date of Birth:_____ Place of Birth:_____

School your child attended before Christ the King?_____
Name City/State

Home Address:_____
_____
Home Phone Number:_____
Father's Name:_____
Business Phone:_____
Cell/Beeper Number:_____
Physician's Name:_____
Physician's Phone Number:_____

Mother's Name:_____
Business Phone:_____
Cell/Beeper Number:_____
Emergency Contact Other than Parent:_____
Emergency Phone Number:_____
Relationship to Student:_____

Please check if your child has had any of the following:

- ☐ **Asthma**
- ☐ **Allergies (*Please list below*)**
- ☐ **Congenital Heart Disease**
- ☐ **Convulsions**
- ☐ **Diabetes**
- ☐ **Cancer**
- ☐ **Tuberculosis**
- ☐ **Orthopedic Problems**
- ☐ **Vision Problems (Glasses?)**
- ☐ **Heart Murmur**
- ☐ **Head/Neck/Back Injury**
- ☐ **Boys: Testicular Problems**
- ☐ **Girls: Menstrual Problems**
- ☐ **Hearing Problems**
- ☐ **Speech Problems**
- ☐ **Physical Handicap**
- ☐ **Hospitalizations**
- ☐ **Surgeries**
- ☐ **Serious Illnesses**
- ☐ **Serious Accidents**
- ☐ **Hernia**
- ☐ **Headaches**
- ☐ **Any family member younger than 45 die suddenly?**
- ☐ **Concussion, or been Knocked Out?**
- ☐ **Seizures, Epilepsy**
- ☐ **Thyroid Disorder**
- ☐ **Kidney Disease**
- ☐ **Eating Disorder**
- ☐ **Rheumatic Fever**
- ☐ **Hypertension**
- ☐ **Ankle/Knee/Foot Problems**
- ☐ **Bleeding Disorders**
- ☐ **Heat Stroke or Fainting**
- ☐ **Chest Pain with Exercise**
- ☐ **Fractures/Dislocations**
- ☐ **Other Problems or Limitations**

Please give a brief description of any conditions you checked above *(attach a separate sheet if needed)*:

Condition: Description: Age/Year of Occurrence:

_____
_____
_____
_____

Is your child currently under any medical treatment? _____ Please Explain_____

_____

Is your child currently taking any form of medication? _____ Please List_____

_____

I give permission for my child to participate in interscholastic sports (teams) according to their physician's recommendations:☐ Yes ☐ No

Do you give permission for your child to be sent home by car service when they are not seriously ill? You will be informed of your child's illness by telephone prior to their being sent home by car service. (*This is only available if there is a responsible adult at home to receive the child and pay the fare*)☐ Yes ☐ No

The above answers are true to the best of my knowledge. Signed_____ Date_____

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SECTION "B": TO BE COMPLETED BY A LICENSED PHYSICIAN:

Child's History _____

_____

_____

_____

_____

Family History _____

_____

_____

_____

_____

Physical Exam:

Height_____Weight_____
Blood Pressure_____ Pulse_____
General Appearance_____
_____
_____

NL	AB	
__	__	**HEENT**
__	__	**DENTAL STATUS**
__	__	**NECK**
__	__	**LYMPH**
__	__	**LUNGS**
__	__	**CARDIOVASCULAR**
__	__	**ABDOMEN**
__	__	**GENITO URINARY**
__	__	**EXTREMITIES**
__	__	**BACK/SPINE**
__	__	**SKIN**
__	__	**NEUROLOGICAL**
__	__	**PSYCHO/SOCIAL DEV.**
__	__	**LANGUAGE**
__	__	**BEHAVIORAL**
__	__	**GROSS MOTOR**
__	__	**FINE MOTOR**

LAB TESTS:
URINE _____ALBUMIN_____SUGAR_____
HEMOGLOBIN_____HEMATOCRIT_____

VISION:
Uncorrected RIGHT_____ LEFT_____
Corrected RIGHT_____ LEFT_____

HEARING:
RIGHT_____LEFT_____

PLEASE LIST ANY REFERRALS STUDENT MAY NEED AT THIS TIME_____
_____

_____

_____

Full Physical Activity? YES____ NO___

Please List Any Restrictions_____
_____
_____
_____

Maturation Index (Optional) _____

DRAW A LINE THROUGH ANY SPORTS THE STUDENT MAY NOT PARTICIPATE IN:

Football	**Volleyball**	**Bowling**
Baseball	**Swimming**	**Golf**
Basketball	**Track & Field**	**Field Events**
Hockey	**Cross-Country**	**Step**
Soccer	**Tennis**	**Cheerleading**
Softball	**Handball**	

Any special conditions for participation (e.g. pre-exercise medication or protective gear):
_____
_____

Physician's Signature_____

Date of Exam_____

Stamp

Please write in address and phone number if they are not on the Physician's Stamp
_____
_____
_____

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MEDICAL OFFICE

Dear Parent or Guardian:

Every student entering Christ the King High School is required to have a complete physical examination including an eye exam. This must be performed by a licensed physician, signed and stamped by his/her office. **The exam must be completed and dated between June 1st and August 1st and returned to the Nurse's office by August 10th.**

Proof of immunization is required.

No student will be permitted to attend school in September unless all requirements have been satisfied. Please call me if you have any questions. Thank you for your cooperation.

Sincerely,

Regina Tuske, RN
Tel (718) 366-7400, ext. 212
Fax (718) 366-1165

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED BY NEW YORK CITY

DTaP, DTP, DT, Td or Tdap	3 doses
Tdap	1 dose (born on or after 1/1/94)
OPV or IPV	3 doses
MMR	2 doses of Measles (MMR) first dose **on** or **after** first birthday Plus second measles, preferably as MMR, administered more than 28 days after the first dose, and **on** or **after** 15 months of age
Hepatitis B	3 doses of pediatric hepatitis B vaccine or 2 doses of the Merck Recombivax HB adult vaccine, given four months apart specify type and dose given
Varicella	1 dose on or after first birthday (born on or after 1/1/94)

Acceptable Immunization Proof:
No. Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR), Section 66-1 defines acceptable proof. This includes documents indicating the required receipt of all vaccines such as certificate of immunization, a signed transcript of the immunization portion of cumulative health record from the prior school, a migrant health record, a union health record, a community health plan record, a signed immunization transfer card, a military dependent's "shot" record, the immunization portion of a passport, a certificate or written physician's statement of medical exemption by a physician licensed to practice in New York State, serological proof of immunity or prior disease history, or a written statement of exemption for religious reasons. The last is the ONLY parental statement that may be acceptable.