

Goshen Central School District  
**SCHOOL HEALTH SERVICES**

Physical exams for school sports are valid for 1 year.

If you choose to have your child examined by your health care provider, please submit the completed medical form to the school health office by **October 1<sup>st</sup>**. If not received by this date, your child will be scheduled for a physical with the school nurse practitioner. Physicals shall be acceptable if performed not more than twelve months prior to the commencement of the school year in which the examination is required.

Vision, hearing and scoliosis screening will be performed according to the New York State guidelines.

*(NYS Law Requires Physicals for Grades: K, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup>, 10<sup>th</sup>, New Entrants and 7<sup>th</sup> - 12<sup>th</sup> Sports Participants)*

- I will have my child examined by my own health care provider. \_\_\_\_ Completed Form Attached  
 The examination has been scheduled for the following date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 I would like my child to be examined in school by the nurse practitioner.

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Vision (R) \_\_\_\_\_ (L) \_\_\_\_\_ Corrected Y N Hearing P F

Parent's / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

**TO BE COMPLETED BY HEALTH CARE PROVIDER**

	Normal	Abnormal				Comments
Gen. Appearance						
Skin, Hair						
Head						
Eyes, Eyelids						
Ears, Eardrums						
Nose, Throat						
Teeth, Gums						
Lymph Nodes, Thyroid						
Lungs						
Heart						
Chest						
Neurological						
Abdomen						
Hernia (if yes, explain)						
Bones, Joints						
Scoliosis						
Urinalysis						
Tanner Stage: I II III IV						Onset of Menarche

- Immunizations Update \_\_\_\_\_  
 Medications \_\_\_\_\_  
 \* (MD note required if administered in school)  
 Known Conditions \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 Restrictions / Protective Gear \_\_\_\_\_  
 Approved for Sports Y N Date of Physical \_\_\_\_\_

Provider Signature \_\_\_\_\_

Print Name or Stamp

Body Mass Index (BMI) \_\_\_\_\_  
 Weight Status Category (Sex-Specific BMI-for-age-percentile)

< 5<sup>th</sup>  85<sup>th</sup> to 95<sup>th</sup>  
 50<sup>th</sup> to 85<sup>th</sup>