

CARMEL CENTRAL SCHOOL DISTRICT HEALTH/ATHLETIC APPRAISAL FORM

NAME _____ DATE OF BIRTH _____ GRADE _____

TO BE FILLED OUT BY PHYSICIAN

B.M.I. _____ PERCENTILE _____ %	H.E.E.N.T. _____
HEIGHT _____ / WEIGHT _____	HEART _____
BLOOD PRESSURE _____ PULSE _____	LUNGS _____
POSTURE-EVIDENCE OF SCOLIOSIS _____	HERNIA _____
OTHER STRUCTURE _____	GENITO-HERNIA _____
NERVOUS SYSTEM _____	SKIN _____
TANNER MATURATION LEVEL <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u>	VISION _____
	HEARING _____

TEETH _____ (teeth injuries will not be paid if teeth are defective) BRIDGE/FALSE TEETH _____ CHIPPED TEETH _____

PLEASE ATTACH IMMUNIZATION RECORD

SPECIFIC ILLNESS/INJURIES DURING LAST 12 MONTHS _____

SIGNIFICANT MEDICAL/SURGICAL HISTORY EXPLAIN _____

SPECIFY CURRENT DISEASES: ASTHMA DIABETES TYPE 1 OR 2 SEIZURE DISORDER CARDIAC OTHER

CONTACT/ COLLISION	LIMITED CONTACT/ IMPACT	STRENUOUS NON-CONTACT	NON-STRENUOUS NON-CONTACT
FIELD HOCKEY	BASEBALL	CROSS-COUNTRY	BOWLING
FOOTBALL	BASKETBALL	TRACK & FIELD	GOLF
LACROSSE	SOFTBALL	TENNIS	
SOCCER	GYMNASTICS		
WRESTLING	CHEERLEADING		
ICE HOCKEY	VOLLEYBALL		
	SKIING		

DOES STUDENT NEED AN INHALER FOR SPORTS? YES _____ NO _____

DOES STUDENT NEED AN EPI-PEN FOR BEE/INSECT ALLERGIES? YES _____ NO _____

IF YOU ANSWERED YES TO EITHER OR BOTH OF THE ABOVE, A CURRENT MEDICATION PERMISSION SLIP AND SELF MEDICATION SLIP MUST BE ON FILE IN THE NURSE'S OFFICE BEFORE A STUDENT IS ALLOWED TO TRY OUT OR PRACTICE SPORTS

THE ABOVE NAMED STUDENT HAS (CIRCLE ONE) FOR SPORTS: UNRESTRICTED APPROVAL SELECTIVE APPROVAL

DISQUALIFIED REASON: _____

SCHOOL PHYSICIAN _____ DATE OF EXAM _____

PRIVATE PHYSICIAN _____ DATE OF EXAM _____

PLEASE STAMP-VOID IF NOT STAMPED
PHYSICIANS NAME
ADDRESS