CARMEL CENTRAL SCHOOL DISTRICT HEALTH/ATHLETIC APPRAISAL FORM

NAME______________________________ DATE OF BIRTH________________ GRADE______

TO BE FILLED OUT BY PHYSICIAN

B.M.I.________ PERCENTILE________%

HEIGHT________/WEIGHT__________

BLOOD PRESSURE__________ PULSE__________

POSTURE-EVIDENCE OF SCOLIOSIS______________

OTHER STRUCTURE______________

NERVOUS SYSTEM______________

TANNER MATURATION LEVEL 1 2 3 4 5

H.E.E.N.T.______________

HEART______________

LUNGS______________

HERNIA______________

GENITO-HERNIA______________

SKIN______________

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

Nmm Revised 9/2010

ATTACHMENTS WILL NOT BE ACCEPTED