CARMEL HIGH SCHOOL

30 FAIR STREET • CARMEL. N.Y. • 845-225-8441 • FAX 845-228-2307

PRINCIPAL
LOUIS T. RIOLO

ASSISTANT PRINCIPAL
JOHN FINK

ASSISTANT PRINCIPAL
LAUREN SANTABARBARA

ASSISTANT PRINCIPAL
BRIAN PIAZZA

July 2016

Dear Parents/Guardians:

Please be advised that New York State requires that all TENTH GRADERS receive a physical examination.

The district can arrange for an examination to be performed in school if the parents choose to have it done by the school physician. However, it is advisable for the examination to be done privately by the physician who ordinarily cares for the child, since that physician will be more familiar with the child and his/her medical history.

Attached you will find the **Annual Physical Examination** form which must be completed by a physician and submitted to the Carmel High School Nurse's office on or before the first day of classes.

Thank you for your prompt attention to this mandate.

Sincerely,

Louis T. Riolo

Louis T. Riolo
Principal

/md

CARMEL CENTRAL SCHOOL DISTRICT
81 SOUTH STREET, P.O. BOX 296
PATTERSON, NEW YORK 12563

Dear Parent:

Our school district is concerned with all aspects of your child's development. To insure that your child's physical health is being monitored, the State of New York requires that each child in grades Kindergarten, 2, 4, 7, 10 and new entrants have a physical examination. Your family physician is best informed about your child's health; therefore, we encourage you to have him/her perform this examination. If you do not have a family physician or prefer the examination be done in school, we will arrange to have your child examined by our school physician,

If your child is in any of the grades listed above, please complete the form below with your preference, and return it to the school nurse in your child's building by September 15.

If you elect to have the physical examination done by your child's physician, please have the examination completed and return the attached physical form by November 3.

Your cooperation in this matter is greatly appreciated.

Sincerely,

Eric M. Stark
Asst. Superintendent of Business

PARENT'S PREFERENCE FOR CHILD'S PHYSICAL EXAMINATION

Name of child:_____Grade:_____

Date of Birth:_____Bldg.:_____ Teacher:_____

I want my child's physical examination done by: (check one)

_____The school physician

_____My child's physician

Name of physician: _____

Date of appointment, if scheduled: _____

Parent's signature: _____ Date: _____

EMS:md
Attach. 08/14

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 1 2 3 4 5 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