JACK M. BARRACK HEBREW ACADEMY
Love where you learn

SCHOOL PHYSICAL & SPORTS PARTICIPATION FORM

Student Name_____ **DOB**_____ **Grade** _____
Student Physician_____ Phone_____

PLEASE ATTACH STUDENT'S IMMUNIZATION RECORD FOR GRADES 6, 11 and ANY NEW Student

Medical History:

Please list any chronic medical conditions such as asthma, diabetes, other?

_____

Please list any allergies to food/medicine/environment _____

May the School Nurse include the above information on a confidential list to teachers? ☐ **YES** ☐ **NO**
Has the student ever been diagnosed with a concussion? ☐ **YES** ☐ **NO** If Yes, Please List Date & Cause_____

INHALER : Medication/Dose/Frequency_____
Student will Self Carry for independent self-administration ☐ **YES** ☐ **NO**

EPIPEN Medication/Dose/Frequency_____
Student will Self Carry for independent self-administration ☐ **YES** ☐ **NO**

INSULIN Medication/Dose/Frequency_____
Student will **Self Carry for independent self-administration** ☐ **YES** ☐ **NO**

Please list any prescription medications the student is currently taking on a regular basis.

Medication Name/Dose	Breakfast	Lunch	Afternoon	Dinner	Evening
	(please circle time of administration)				
1.	B	L	A	D	E
2.	B	L	A	D	E
3.	B	L	A	D	E
4.	B	L	A	D	E

Are there any physical restrictions for the student in Physical Education activities or Sports? ☐ **YES** ☐ **NO**
If YES, Please specify: _____

FINDINGS UPON PHYSICAL EXAM

Blood Pressure _____ **Pulse**_____ **Height**_____ **Weight**_____ **BMI #** _____/____%

Is the BMI in Recommended Range? ☐ **YES** ☐ **NO** **Was Counseling Initiated?** ☐ **YES** ☐ **NO**

Is scoliosis present? ☐ **YES** ☐ **NO Under Care?**_____

Vision: FAR: Right_____ **NEAR: Right**_____
Left_____ **Left**_____
OU_____ **OU**_____

Hearing: Right_____ **Left**_____

A Physical Exam was performed within the past 12 months and the student was found to be free of contagious disease? YES____ NO____

I have examined the above student on _____ and have medically cleared the student to participate in sports and physical activities, both intramural and inter-scholastic, during the school year_____.

_____ _____ **STAMP:**
Health Care Provider Signature Date