



**Bethlehem Central High School**  
 700 Delaware Ave.  
 Delmar, NY 12054  
 (518) 439-4921

**Bethlehem Central Middle School**  
 332 Kenwood Ave.  
 Delmar, NY 12054  
 (518) 439-7460

**FOR:** Grades 7 and 10 Physical  
 Entering Students  
 Interscholastic Sports  
 Working Certificate

## PHYSICAL APPRAISAL REPORT

**SPORT:** \_\_\_\_\_

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_ Gender: M or F  
 Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

### HEALTH HISTORY

*To be completed by physician. Physicians please answer YES or NO. Use reverse side to explain YES answers.*

Heart Disease _____	Hernia _____	Fracture _____
Kidney Disease _____	Bleeding Disorder _____	Dislocation _____
Lung Disease _____	Allergy _____	Operation _____
Need For Medication _____	Congenital Defects _____	

### PHYSICAL

Immunizations during past year (list type and date given) \_\_\_\_\_

Height _____ Weight _____ Eyes (R) _____ (L) _____ Ears (R) _____ (L) _____ Blood Pressure _____ Pulse _____ Teeth _____ Gums _____ Tonsils _____ Glands: Cervical _____ Thyroid _____ Other (Specify) _____ Cardiac: Upright _____ Supine _____ Femoral Pulses _____	Body Mass Index _____ <u>Weight Status Category (BMI Percentile)</u> <input type="checkbox"/> Less than 5th <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 94 <sup>th</sup> through 99 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher Nervous System (specify if Epilepsy) _____ Skin _____ Body Habitus _____ Abdomen _____ Orthopedic: Structural Defect _____ Scoliosis (See Reverse If Positive) _____ Feet _____ Lungs _____ Speech _____ Hernia _____ Tanner: Male/Female    1    2    3    4    5 Female – Onset Menstruation _____
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This certifies that the above named student is physically qualified to participate in the following categories of competition during the school year 20\_\_\_\_ – 20\_\_\_\_\_

Check the boxes for the category in which an athlete may qualify:

**Contact or Collision Sports**  
 Football/Baseball/Basketball  
 Soccer/Field Hockey/Ice Hockey/Diving  
 Wrestling/Lacrosse/Softball  
 Volleyball/Cheerleading/Gymnastics

**Endurance Activities**  
 Swimming/Tennis  
 Cross Country/Track and Field

**Others**  
 Bowling/Golf

Reason For Disqualification: \_\_\_\_\_

Date of Physical: \_\_\_\_\_ Examiner's Signature: \_\_\_\_\_

*Physician's Stamp*

Reviewed and approved for sports \_\_\_\_\_ School Physician, Date \_\_\_\_\_

Student Name \_\_\_\_\_ Date \_\_\_\_\_

Additional health history information: \_\_\_\_\_  
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*Article 19 Section 905 of the New York State Education Law requires annual scoliosis screening for each child between the ages 8 and 16.*

Please check for any positive findings:

- 1. Forward bend
  - Thoracic Prominence                      L (    )                      R (    )
  - Lumbar Prominence                      L (    )                      R (    )
- 2. Shoulder Higher                      L (    )                      R (    )
- 3. Prominent Scapula                      L (    )                      R (    )
- 4. Elevated Scapula                      L (    )                      R (    )
- 5. Iliac Crest Higher                      L (    )                      R (    )
- 6. Arm to Body Space Greater                      L (    )                      R (    )
- 7. Recommendations:

Physician's Signature: \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_