



GRADE 7/10 PHYSICAL
NEW ENTERING STUDENTS
INTERSCHOLASTIC SPORTS
WORKING CERTIFICATE

High School
1 Sabre Drive
Schenectady, NY 12306
FAX: 1-518-355-7025

SPORT: _____

Name: _____ (M) (F) Grade: _____ Homeroom: _____

Middle School
2 Sabre Drive
Schenectady, NY 12306
FAX: 1-518-355-5329

Address: _____ Birthdate: _____

HEALTH HISTORY

Physicians please answer yes or no. Use reverse side to explain yes answers.

Heart Disease _____ Hernia _____ Fracture _____
Kidney Disease _____ Bleeder _____ Dislocation _____
Lung Disease _____ Allergy _____ Operation _____
Need for Medication _____ Congenital Defects _____

PHYSICAL

Recent Immunizations: _____

BMI _____ / Weight Status Category _____

Height _____ Normal Pulse _____
Weight _____ Pulse after 25 hops on one foot _____
Blood Pressure _____ Pulse after 2 minutes rest _____
Eyes: (R) _____ (L) _____ Ears: (R) _____ (L) _____ Nutrition: _____
Teeth: _____ Gums: _____ Tonsils: _____

Glands: _____ Orthopedic: _____
Cervical _____ Structural defect _____
Thyroid _____ Scoliosis _____
Other (Specify) _____ Posture _____
Feet _____

Heart: _____ Lungs: _____
Nervous System (specify if epilepsy): _____ Speech: _____
Skin: _____ Hernia: _____

Urine Testing:
Sugar _____
Protein _____

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year.

This certification is void if the pupil is absent from school for 5 or more days because of a significant injury or illness. A new certificate must be issued before he/she is allowed to participate.

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

Contact or collision

[]

Football/Baseball
Hockey (field/ice)/
Wrestling/Lacrosse
Softball/Basketball/Soccer

Endurance activities

[]

Gymnastics/Swimming/
Diving/Tennis
Cross Country/Volleyball/
Track & Field/Skiing

Others

[]

Bowling/
Golf/
Cheerleading

Reason for Disqualification: _____

Date of Physical _____ Physician's Signature _____

Physician's Stamp _____

Reviewed and Approved _____ School Physician _____ Date _____