



JONES BEACH JUNIOR LIFEGUARD CORPS - HEALTH CERTIFICATE

PHYSICIANS PLEASE NOTE: Sports PX. - lines with arrows must be completed.

Name: _____ Gender: M F Date of Birth: _____ Grade: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

9th /10th grade only Body Mass Index: _____

Weight Status Category (BMI Percentile):

less than 5th 5th through 49th 50th through 84th

85th through 94th 95th through 98th 99th and higher

	Referral		
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality: _____

MEDICATIONS (INCLUDING OVER THE COUNTER)

Medications (list all including Inhaler / Tylenol / Advil / Epi-Pen): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If A.M. dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

Parent Signature: _____ Date: _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / EMPLOYMENT QUALIFICATION / CSE COMMITTEES

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension

Other: _____

Physician's Signature: _____

Phone: _____ Fax: _____

OFFICE STAMP