Maria L. Varisco-Rogers Charter School
Providing new alternatives for a better education
233 Woodside Avenue
Newark, NJ 07104
Tel: (973) 481-9001 Fax: (973) 481-9009
E-mail:Office@mlvrcs.org
Website: http://www.mlvrcs.org

Student Information

Student's Name: _____

Sex: M / F (Circle one)) Age: _____ Grade: _____ Date of Birth: _____

Address:_____

City/State/Zip Code: _____ Telephone: _____

Parent's/Guardian's Full Name: _____

Physician Information

Name:_____

Address: _____

City/State/Zip Code: _____

Telephone:_____Fax:_____

Physician or Provider Information - Please Complete Both Pages

Height: _____ Weight: _____ Blood Pressure: ____/____ Pulse: _____bpm Hearing _____

Vision: R 20/ _____ L 20/ _____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

Indicators	Normal? (Circle One)		Abnormal Findings / Comments
Head / Neck	YES	NO	
Eyes / Sclera / Pupils	YES	NO	
Ears	YES	NO	
Nose / Mouth / Throat	YES	NO	
Heart: Murmurs / Rhythms	YES	NO	
Lungs: Auscultation / Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. Liver, spleen)	YES	NO	
Tanner Stage: Testes / Onset of Menses:	YES	NO	
Neck / Back / Spine: Range of Motion:	YES	NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination: Romberg:	YES	NO	
Heel Walk:	YES	NO	
Tanderm Walk	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if no / possible, please explain)	YES	NO	

Most recent Immunizations / Dates:
Medications currently being used:
Additional Observations:

General
Diagnosis_____

Recommendations: _____

Student MAY participate in the following sports: (CHECK ALL THAT APPLY)

____ CONTACT/ COLLISION ____ NON-CONTACT / STRENUOUS

____ LIMITED CONTACT ____ NON-CONTACT / NON-STRENUOUS

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

_____

_____

Conditions requiring clearance before sports participation include, but are not limited to: Arlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellilus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

EXAMINED BY: Physician's / Provider's Stamp:

Family Physician / Provider _____

School Physician _____

_____ MD _____ DO _____ NP _____ PA

Physician's / Provider's Signature: _____ Date: _____

NOTE TO SCHOOL PHYSICIANS: Pursuant to N.J.A.C. 6A:16-2.2, the school physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student's permanent health record.