*NYSED requires an annual physical exam for new students in Grades K, 2, 4, 7 and 10, sports, working papers and triennially for the Committee on Special Education (CSE)*

# HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: ❑ M ❑ F Grade: _____

I give permission for the exam to be done in school: Parent Signature: _____ Date: _____

## IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached ..... Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: _____

❑ No immunizations given today ..... PPD: ❑ Positive ❑ Negative ❑ Not done Date: _____

❑ Immunizations given since last Health Appraisal: ..... Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: _____

Dental Referral: ❑ Yes ❑ No ❑ Not done Date: _____

**Significant Medical/Surgical History:** ❑ See attached _____

_____

Allergies: ❑ LIFE THREATENING ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____

❑ Seasonal ❑ Medication: _____ _____

## PHYSICAL EXAM

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

| | | | Referral |
|---|---|---|---|
| Body Mass Index: ____ ____ . ____ | Vision - without glasses/contact lenses | R _____ | L _____ |
| Weight Status Category (BMI Percentile): | Vision - with glasses/contact lenses | R _____ | L _____ |
| ❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th Hearing | Vision - Near Point | R _____ | L _____ |
| ❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher | Hearing ❑ Pass 20 db sc both ears or: | R _____ | L _____ |

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

Specify any abnormality (use reverse of form if needed): _____

_____

_____

## MEDICATIONS

Medications (list all): ❑ None ❑ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❑ Yes ❑ No
Note: Nurse will also assess self-direction for the school setting.

Student may self carry and self administer medication ❑ Yes ❑ No
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

## PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

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

____ Limited contact: cheer leading, 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: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

*This exam complies with NTSED requirements above and is valid for twelve months, with the exception of illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director Rev2/08*