Health Certificate/Appraisal Form

NYSED require an annual physical exam for new entrants, students in grades K, 2, 4, 7, and 10, sports, working permits, and for the Committee on Special Education (CSE) initially and triennially.

Name: _____ Date of Birth: _____

Date of Exam: _____ Gender: □F □M Grade: _____

IMMUNIZATIONS/HEALTH HISTORY

□Immunization record attached

□No immunizations given today

□Immunizations (and dates given) since last Health Appraisal

_____

Sickle Cell Screen: □Positive □Negative □Not Done Date:_____

PPD: □Positive □Negative □Not Done Date:_____

Elevated Lead: □Yes □No □Not Done Date:_____

Dental Referral □Yes □No □Not Done Date:_____

Significant Medical/Surgical History: □See attached _____

_____

Allergies: □ Food: _____□ Insect: _____□ Medication: _____□ Seasonal: _____

□ Other: _____□ Known Reaction: _____□ **LIFE THREATENING**

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

				Referral
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	Vision – without glasses/contact lenses	R	L	
	Vision – with glasses/contact lenses	R	L	
	Vision – Near Point	R	L	
	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: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

□ Student needs to take medicine during school. School Nurse should have the required medication administration form completed.

PHYSICAL EDUCATION/SPORTS/PAYGROUND/WORK QUALIFICATION/CSE CONSIDERATION

□ Free for contagion & physically qualified for all physical education, sports, playground, work & school activites OR only as checked

□Limited Contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball

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

□Specify medical accommodations needed for school: _____

□Known or suspected disability: _____

□Restrictions: _____

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

OTHER INFORMATION

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

□Other: _____

Healthcare Provider's Signature: _____ Phone: _____

Healthcare Provider's Name/Address: _____ Fax: _____

If completed this exam complies with NYSED requirements and is valid for twelve months from the date of the exam, with the exception of any illness or injury lasting more than five days that will require review by the private Healthcare Provider and the School Chief Medical Officer