

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: _____

Body Mass Index: _____	Vision - without glasses/contact lenses	R _____	L _____
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R _____	L _____
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th Hearing	Vision - Near Point	R _____	L _____
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R _____	L _____

Referral

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 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

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