*Recommended / Sample Form*

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

# EARLY AND SCHOOL AGE CHILD HEALTH CERTIFICATE / APPRAISAL FORM

**Name:** _____ **Date of Birth:** _____

**School:** _____ ☐ NA **Gender:** ☐ **M** ☐ **F** **Grade:** _____ ☐ NA

## IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations 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 _____

**Specify current diseases:** ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
Other: _____

**Allergies**: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

## PHYSICAL EXAM

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

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 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 ☐ NA Student may self carry and self administer medication ☐ Yes ☐ No ☐ NA
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.

## EARLY INTERVENTION/DAYCARE/PRE-SCHOOL/PHYS. ED./ SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE

☐ **Free from contagions & physically qualified for all activities, Phys. Ed., sports, playground, work, home, school 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**: _____ ☐ SLP ☐ OT ☐ PT
☐ **Known or suspected disability:** _____
☐ **Restrictions:** _____
☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

*This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.* *Rev. 2/08*