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).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: **Date of Birth:** __

School: **Gender:** ❑ **M** ❑ **F** **Grade:**

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

Allergies: ✕ **LIFE THREATENING** ✕ Food: ✕ Insect: ✕ Other:
✕ Seasonal ✕ Medication:

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ 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 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: 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 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

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*

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

✕ Other:

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

Provider's Name/Address: _____ Fax: _____

Parent Signature: Date:

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AREA OR SYSTEM	ABNORMAL FINDINGS
Eyes	
Ears, Nose, Throat	
Mouth, Teeth	
Thyroid	
Lymph Nodes	
Skin	
Chest, Lungs	
Heart	
Abdomen	
Genitalia (Tanner) □ Refuse □ Student states both testicles down, no masses	
Musculoskeletal	
Neck, Spine, Posture	
Shoulders	
Arms, Elbows, Hands	
Hips, Thighs	
Ankles, Feet	
ROM, Strength	
Knees	

Smoke:_____ ETOH:_____ Drug:_____

CP, SOB or dizzy with ex:_____

Concussion:_____ Mono:_____

Family History Early Cardiac:_____

Joint or Muscle Problem:_____

Referrals/Recommendation:_____

_____

_____

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