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:** _____________ **Date of Exam:** ____________

School: ____ **Gender:** Male_____ Female______ **Grade:**_________________

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ Immunizations given since last Health Appraisal:

❒ Dental Referral ❒ Yes ❒ No ❒ Not done Date_________
❒ Elevated Lead ❒ Yes ❒ No ❒ Not done Date_________

Significant Medical/Surgical History

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: ____

Surgeries/Date:____
____

Allergies: ❒ **LIFE THREATENING** ❒ Food: _____________ ❒ Insect: ___________________ ❒ Other: ________________________
❒ Seasonal ❒ Medication: ____________________________________

MEDICATIONS

Medications (list all): ❒ None

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 EXAM

Height: ______________ Weight: ______________ Blood Pressure: ______________ Pulse: _____________

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

❒ **Tanner: I. II. III. IV. V.** **Scoliosis: ❒ Negative ❒ Positive:** _______________

❒ **FEMALE TRIAD SCREENING ___ Negative ___ Positive (specify ___ disordered eating ___ amenorrhea ___ osteoporosis)**
Date of Last Menses __________ Further Evaluation Needed ______________________________

☐ **EXAM ENTIRELY NORMAL Specify** any abnormality____
____

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

❒ **Free from contagions & physically qualified for all physical education, sports, and playground and 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, weight train, crew, dance, track, run, walk, rope jump.

❒ **Working Papers: Physically qualified for lawful employment.**

❒ **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: ________________________

Provider's Signature: ____ Phone: ________________________ (Stamp below)

Provider's Name/Address: ____________________________________ Fax: ________________________

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. 3/11