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:

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. ❒None
___ 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**:

❒ **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:

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*