Print Form

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: ____ ____ . ____	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	

☐**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

Student Name ____________

	Yes	No	Dates
Asthma			
Respiratory Disorder			
Anemia (including Sickle Cell)			
Hepatitis			
Mononucleosis			
Diabetes			
Thyroid Disorder			
Eye, Ear, Throat Disorder			
High Blood Pressure			
Heart Disorder			
Gastrointestinal Disorder			
Kidney/Genitourinary Disorder			
Epilepsy or Convulsive Disorder			
Concussion/Number ____________			
Frequent or Severe Headaches			
History of Fainting or Dizziness			
Heatstroke			
Absence of Paired Organ			
Other Organ Disorder			

*Yes to any of the above, please explain ____

Known Allergies ____

Medications being taken regularly/Purpose ____

	YES	NO
Do you wear Protective Lenses, Eyeglasses or contact Lenses?	____	____
Do you wear any type of dental appliance?	____	____
Have you been hospitalized for any reason?	____	____
Have you ever been denied athletic participation for medical reasons?	____	____
Do you have any other type of illness, injury or condition, which is being monitored by a Doctor?	____	____

*YES to any of the above, please explain ____

SPORT(S) STUDENT IS INTERESTED IN ____

II. Orthopedic History and Information (to be completed by parent or guardian)

Include any major musculoskeletal injury to the following areas:
Include sprains, dislocations? fractures, and surgery.

	Right	Left	Date	Description of Injury
Foot				
Ankle				
Lower Leg				
Knee				
Thigh				
Hip				
Spine				
Shoulder				
Upper Arm				
Forearm				
Wrist				
Hand				
Head				
Neck				
Other				

Failure to report a medical problem will constitute reason to exclude the student from the Athletic Program. I DECLARE THE ABOVE INFORMATION TO BE ACCURATE,

____ ____________________________