KENNEDY CATHOLIC HIGH SCHOOL

Founded as St. Mary's High School 1924-1966

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: ________ Pulse ______ Date of Exam: ________

Body Mass Index: ______ ______ . ______				*Referral*
	Vision - without glasses/contact lenses	R	L	
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 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

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*

Student Name:____

Indicate if your child or any member of your family have or have had the following illnesses or disorders by marking (S) for student and (F) for family member in the appropriate box.

	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, fractions, 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 a reason to exclude the student from the Athletic Program.
I DECLARE THE ABOVE INFORMATION TO BE ACCURATE,

____ ________________________________ (OVER)
Signature of Parent or Guardian Date