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

Please attach updated Immunization record
☐ No immunization given today

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 _____
☐ Seasonal ☐ Medication _____ ☐ Other _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse:_____ Date of Exam: _____

				Referral
Body Mass Index: _____ _____ . _____	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 ☐ 50 through 84th	Vision – Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:			

☐ **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-county, 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.10/08

CC: Nurse