# ALLEGANY COUNTY SCHOOLS

## HEALTH CERTIFICATE / APPRAISAL FORM

*NYSED requires an annual physical exam for new entrants, students in Grades Universal Pre-K, K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).*

Student: ____________________________________________ Date of Birth: ____________________

School: ______________________________ Gender: ☐ M ☐ F Grade: __________

Student's Primary Doctor/Physician: ____________________________________________

## IMMUNIZATIONS / HEALTH HISTORY

☐ **Please attach current immunizations.**

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: __________

PPD: ☐ Positive ☐ Negative ☐ Not done Date: __________

Elevated Lead: ☐ Positive ☐ Negative ☐ Not done Date: __________

Dental Referral: ☐ Positive ☐ Negative ☐ Not done Date: __________

**Significant Medical/Surgical History:** ☐ See attached ____________________________________________

____________________________________________

**Allergies:** ☐ **LIFE THREATENING** ☐ Food: ______________ ☐ Insect: __________ ☐ Other: __________

☐ Seasonal ☐ Medication: ____________________________________________

## DATE OF PHYSICAL EXAM: ________________

Height: __________ Weight: __________ Urinalysis: ____________

Temperature: ______ Pulse: __________ Respirations: ____________ Blood Pressure: __________

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: ____________________________________________

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, soccer, basketball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, rifleman, weight train, crew, dance, track, run, walk, rope jump, roller skating.

☐ **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 ☐ Helmet ☐ Other:

## ADDITIONAL 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's Signature: ______________________________ Date: ______________