



## South Buffalo Charter School Physical Exam Notification

New York State Education Law requires a physical exam for all students in grades **Kindergarten, 2, 4, and 7** as well as, students **new** to South Buffalo Charter School and those participating with any school sponsored **sports team**.

Please.....

- Check with your child's doctor if a physical exam was done within the past 12 months and submit a copy to the school in September.

**OR**

- Download the physical form from the SBCS website [Health Services Page](#) or pick up a copy from our Health Office.
- Schedule an appointment with your child's doctor and have them complete the form.
- Return the completed physical form to the Health Office in September when your child returns to school.

Your prompt attention and cooperation are greatly appreciated.

Beth Maloney RN  
Lisa Inglut RN

School Health Services

## 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: _____   | Vision - without glasses/contact lenses                      | R | L | <i>Referral</i> |
| Weight Status Category (BMI Percentile):   | Vision - with glasses/contact lenses                         | R | L |                 |
| <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>    | Vision - Near Point  | R | L |                 |
| <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher | Hearing <input type="checkbox"/> 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: \_\_\_\_\_