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

Spackenkill Union Free School District

Nassau School____ Hagan School____ Todd M.S._____ Spackenkill H.S._____

Name: ______________________________ Date of Birth: ______________________

Gender: ☐ M ☐ F Current 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	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 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: __________

Provider's Name (printed): ______________________ Address: __________

Parent Signature: ______________________ Date: __________