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

❒ 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: ___ ___ . ___				*Referral*
Weight Status Category (BMI Percentile):	Vision - without glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - with glasses/contact lenses	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	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.
___ 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: __________

PREPARTICIPATION MEDICAL HISTORY

This section should be completed by parent/guardian and athlete prior to the time of the medical examination and taken by the student to the examination site for review by the medical examiner.

Have you ever had any of the following conditions? *PLEASE EXPLAIN ANY "YES" ANSWERS*	
Heart Murmur	☐Yes ☐No
High Blood Pressure	☐Yes ☐No
Other Heart Problems	☐Yes ☐No
Fainting or Passing out - -If so, how many times and when:	☐Yes ☐No
Ever been Knocked out – If so, how many times and when:	☐Yes ☐No
Concussion - -If so, Please give dates and outcome, hospitalized, etc	☐Yes ☐No
Seizure or Epilepsy - - If so, when was last seizure	☐Yes ☐No
Asthma or breathing difficulties	☐Yes ☐No
Other Respiratory Problems	☐Yes ☐No
Ever had to stop running after a short distance due to chest pain, palpitations, dizziness, or shortness of breath	☐Yes ☐No
Anemia, Sickle Cell Trait, or Blood disorder	☐Yes ☐No
Mononucleosis - - If so, when	☐Yes ☐No
Diabetes or High Blood Sugar	☐Yes ☐No
Low Blood Sugar	☐Yes ☐No
Arthritis or Joint Problems	☐Yes ☐No
Broken bones If so, describe:	☐Yes ☐No
Any glasses, contacts, or vision Problems - - If so, describe:	☐Yes ☐No
Any Dental Appliances during sports - - If so, describe:	☐Yes ☐No
Any skin disorders - - If so , describe:	☐Yes ☐No
Do you have only one of a normally paired organ (i.e. Kidney, testicle, ovary, eye)	☐Yes ☐No
Do you require any special sports requirements (i.e. Knee braces, neck rolls, foot orthotics, etc.)	☐Yes ☐No
Have you ever been hospitalized? - - If so, why and when:	☐Yes ☐No
Have you had any operations? If so, describe:	☐Yes ☐No
Have you ever had an illness lasting a week or more?	☐Yes ☐No
Have you ever had allergies to the following:	
*Bee Stings If so, Do you require an Epi-Pen?	☐Yes ☐No
*Foods - - If so, what foods:	☐Yes ☐No
*Medicine - - If so, which medications and reactions:	☐Yes ☐No
Do you take any medicines regularly or periodically?	☐Yes ☐No
Which medications:	☐Yes ☐No
Do you wear contact lenses, eyeglasses, or dental appliances? (Circle those that apply)	☐Yes ☐No
Do you have any missing or non-functioning organs?	☐Yes ☐No
Do you have any other health problems?	☐Yes ☐No
Has any family member had a heart attack, heart problems, or sudden death before the age of 50?	☐Yes ☐No
Females: Have you begun menses yet?	☐Yes ☐No
Have you had a series of Hepatitis B shots?	☐Yes ☐No
Date of last Tetanus Immunization ___/___/___	☐Yes ☐No
Have you ever been denied full participation in athletic activity? - - If so, Why:	☐Yes ☐No
Questions or concerns regarding this student's medical history?	☐Yes ☐No

Mandatory Section

Parental Signature________________________________ Date________________

Name of Child's Doctor ____

Doctor's signature indicating review and agreement if done by Child's Primary Provider
____ Date______________

My signature below indicates I request my child receive a sport's physical at school:

____ Date______________