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).

EARLY AND SCHOOL AGE CHILD HEALTH CERTIFICATE / APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

School: ______________________ NA **Gender:** **M** **F** **Grade:** __________ NA

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 ______________________

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
Other: ______________________

Allergies: **LIFE THREATENING** Food: __________ Insect: __________ Other: __________
Seasonal Medication: __________

PHYSICAL EXAM

Height: __________ Weight: __________ Blood Pressure: __________ Pulse______ 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 NA Student may self carry and self administer medication Yes No NA

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.

EARLY INTERVENTION/DAYCARE/PRE-SCHOOL/PHYS. ED./ SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE

Free from contagions & physically qualified for all activities, Phys. Ed., sports, playground, work, home, school 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: ______________________ SLP OT PT

Known or suspected disability: ______________________

Restrictions: ______________________

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: __________

(Stamp below)

Provider's Signature: ______________________ Phone: __________

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.