

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____
School: **Minisink Valley Central School District** 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 _____

History of Concussion/Head Injury (give dates): _____

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

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Referral

Body Mass Index: _____	Vision – without glasses /contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision – with glasses/ contact lenses	R	L	
<input type="checkbox"/> less than 5" <input type="checkbox"/> 5" through 49" <input type="checkbox"/> 50" through 84"	Vision – Near Point	R	L	
<input type="checkbox"/> 85" through 94" <input type="checkbox"/> 95" through 98" <input type="checkbox"/> 99" 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 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 contagious & physically qualified for all physical education, sports, playground, work & school activities OR only as checked :

____ Limited contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, baseball, floor hockey, softball.

____ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, weight train, 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 Sports 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: _____

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 reviews by private healthcare provider and the school medical director.

Student Health Appraisal Supplement For Body Mass Index and Weight Status Reporting

This information is required under New York State Education Law, Section 903. This form should be completed by your physician and returned to the school nurse. The form will be a part of the student's cumulative health record.

Student Name: _____ Date of Birth: ____ / ____ / ____

Gender: male female

Grade: kindergarten 2 4 7 10

Date of Measurement: ____ / ____ / ____

Body Mass Index (BMI): _____.

Weight Status Category (Based on BMI percentiles for age and gender):

- (Check ONE)
- Less than 5th
 - 5th through 49th
 - 50th through 84th
 - 85th through 94th
 - 95th through 98th
 - 99th and higher

Specify current diseases (Check ALL that apply):

- Asthma
- Diabetes, Type 1
- Diabetes, Type 2
- Hyperlipidemia (High Cholesterol or Triglycerides)
- Hypertension (High Blood Pressure)