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).

South Lewis Central School District
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: _____ _____ - _____

Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
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: _____

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.

HEALTH HISTORY FOR SPORTS PARTICIPATION

***Note: This form must be completed within 30 days prior to the start of each sport's season for each athlete.**

Student:_____ Date of Birth:_____

Grade (check): o7 o8 o9 o10 o11 o12 Age:_____

Date of Last Health Appraisal: ____/____/____ Limitations: oYes oNo

Reason for Limitations: _____

Type of Activity Restrictions: _____

Note: "Yes" to any of these questions does not mean automatic disqualification from participation. However, it may require a review and/or approval by a physician before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL/PHYSICAL:

If the answer to any of the following questions is "YES", please describe the condition or situation that prompted your answer in the space below.

1.	Any injuries requiring medical attention?	oYes oNo
2.	Any illness lasting more than five (5) days?	oYes oNo
3.	Taking medicine or under physician's care at this time?	oYes oNo
4.	Any feeling of faintness, dizziness or fatigue after exercise?	oYes oNo
5.	Change in wearing glasses or contact lenses?	oYes oNo
6.	Any surgical operations or fractures?	oYes oNo
7.	Any treatment in a hospital or emergency room?	oYes oNo
8.	Developed any allergies?	oYes oNo
9.	Any chronic disease?	oYes oNo
10.	Is there any reason that your child should not participate?	oYes oNo

Describe the condition or situation that caused any questions to be answered "YES", use back if necessary._____

_____

_____

_____

I, the undersigned, clearly understand the questions are asked in order to decide if my child can safely participate. The answers are correct as of this date and he/she has my permission to participate.

Signed: _____ Date: ____/____/____

Last Update: 9/26/11 MGR