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: ________

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Significant Medical/Surgical History: ☐ See attached ______________________________

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☐ **History of Concussion/Head Injury (give dates):**______________________________

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 5” ☐ 5” through 49” ☐ 50” through 84”	Vision – Near Point	R	L	
☐ 85” through 94” ☐ 95” through 98” ☐ 99” 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): ______________________________

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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.