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). Revised 6/09

JAMESVILLE-DEWITT 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: _____

Chronic Medical Conditions and Significant Medical/Surgical History: ❑ See attached _____

Allergies: ❑ LIFE THREATENING ❑ Food: _____ ❑ Insect: _____

(Emergency care plan will be needed)

❑ Seasonal ❑ Medication: _____ ❑ Other: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse_____ 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 _____

MEDICATIONS

Medications which are administered **at home** (list all): ❑ None

Name: _____ Dosage/Time: _____ Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____ Name: _____ Dosage/Time: _____

MEDICATIONS TO BE ADMINISTERED AT SCHOOL MUST BE ORDERED BY LICENSED PRESCRIBER ON SEPARATE WRITTEN ORDER.

I assess this student to be self-directed ❑ Yes ❑ No **Note: School Nurse will also assess self-direction for the school setting.**

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.

To be completed by a parent or guardian:

Child's name _____

Physician to be called in case of emergency:

_____ Phone _____

Dear Parents,
The Education Law of New York State requires every child to have a physical examination upon entering the school district for Kindergarten or as a TRANSFER student, in GRADES 2, 4, 7, 10, and for sports participation. We urge this examination be done by the family physician who knows your child best and can give a complete examination including tests and immunizations. We encourage continuance of regular physicals in other grades.

If your child is **unable** to have a physical exam by a private physician, please contact the school nurse to arrange a physical at school.

Permission granted to school practitioner to examine my child:

_____ Phone _____

Has your child had any illnesses, serious injury, communicable disease, or surgery since last September? No _____ Yes _____

Please give details and dates _____

_____

_____

Father's Name _____

Phone (h) _____ (w) _____ (c) _____

Mother's Name _____

Phone (h) _____ (w) _____ (c) _____

If there is no one home when your child is ill or injured, please give us the name of a neighbor or relative who will take care of your child: _____

Phone (h) _____ (c) _____

Additional remarks or other conditions: (please notify the school nurse)

_____

_____

_____

HEALTH HISTORY - To be completed by a parent or guardian:

Child's name _____ **Grade** _____

	NO	YES
General		
1. Presently receiving medical care for any condition	_____	_____
2. Taking medicine on a regular basis	_____	_____
3. Any allergies-food, bee sting, environmental, animals	_____	_____
Type of reaction _____		
Medications taken _____		
4. Diabetes	_____	_____
5. Prior surgery	_____	_____
6. Bleeding tendency-severe or frequent nosebleeds	_____	_____
7. Jaundice (other than newborn period)	_____	_____
8. Infectious mononucleosis-enlarged spleen	_____	_____
Eyes		
9. Contact lenses or glasses	_____	_____
10. Amblyopia or strabismus (lazy eye)	_____	_____
Ears		
11. Any difficulty hearing	_____	_____
Respiratory		
12. Asthma	_____	_____
Medications _____		
13. Difficulty breathing	_____	_____
14. Tuberculosis or positive skin test	_____	_____
15. Any reason for chest x-ray	_____	_____
Cardiovascular		
16. Heart disease	_____	_____
17. Heart surgery	_____	_____
18. Hypertension (high blood pressure)	_____	_____
Musculoskeletal		
19. Fractures or dislocations	_____	_____
20. Muscle, bone or joint disability or pain	_____	_____
Neurological		
21. Seizure disorder, ever had a seizure or convulsion	_____	_____
22. Previous head injury or unconsciousness	_____	_____
23. Ever been examined by a neurologist	_____	_____
Renal		
24. Kidney disease, difficulty or frequency of urination, blood in urine	_____	_____

REMARKS: Please elaborate on any "YES" notation above.

_____

_____

_____

_____ _____

PARENT/GUARDIAN SIGNATURE Date