

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____
School: **Newark 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 _____

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
Weight Status Category (BMI Percentile): Vision - with glasses/contact lenses
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th Vision - Near Point
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher Hearing ☐ Pass 20 db sc both ears or: _____

☐ 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: _____