

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).

**HEALTH CERTIFICATE / APPRAISAL FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Gender  M  F Grade: \_\_\_\_\_

IMUNIZATIONS / HEALTH HISTORY	
<input type="checkbox"/> Immunization record attached	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____
<input type="checkbox"/> No immunizations given today	PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____
<input type="checkbox"/> Immunizations given since last health appraisal	Elevated Lead: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____
	Dental Referral <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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: \_\_\_\_\_ Referral

Body Mass Index: \_\_\_\_\_ Vision - without glasses/contact lenses R L

Weight Status Category (BMI Percentile):

less than 5th  5<sup>th</sup> through 49<sup>th</sup>  50<sup>th</sup> through 84<sup>m</sup>  85<sup>th</sup> through 94<sup>1</sup>  95<sup>th</sup> through 98<sup>th</sup>  99<sup>th</sup> and higher  
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 (used 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 1 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 need 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: \_\_\_\_\_

Physical will be conducted on:  
 Date \_\_\_\_\_  
 Time \_\_\_\_\_

Grade \_\_\_\_\_

**Athletic Health History**

School Name: \_\_\_\_\_

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

**Sports Activities**

Identify any sports in which you do not wish your child to participate:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THIS FORM MUST BE COMPLETED AND RETURNED ON THE DAY THE ATHLETE HAS HIS/HER PHYSICAL. THE APPOINTMENT DATE FOR THE PHYSICAL EXAINATION IS IN THE UPPER LEFT HAND CORNER**

**HEALTH HISTORY  
 TO BE COMPLETED BY PARENT**

Has your child ever had: (please check)

	Yes	No		Yes	No
Allergies/Hay fever	<input type="radio"/>	<input type="radio"/>	Elevated Blood pressure	<input type="radio"/>	<input type="radio"/>
Bee Sting Allergy	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Head Injury/Concussion	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Heart Problem/Murmur-chest pain	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Nose Bleeds/Frequent or Severe	<input type="radio"/>	<input type="radio"/>
Bladder/Kidney Problem or Injury	<input type="radio"/>	<input type="radio"/>	Ankle Injury	<input type="radio"/>	<input type="radio"/>
Convulsions/Seizures	<input type="radio"/>	<input type="radio"/>	Back Pain/Injury	<input type="radio"/>	<input type="radio"/>
Fainting Spells	<input type="radio"/>	<input type="radio"/>	Fracture-Dislocation Bones/Joints	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Knee Pain/Injury	<input type="radio"/>	<input type="radio"/>
Ear Problems/Hearing Loss	<input type="radio"/>	<input type="radio"/>	Neck Injury	<input type="radio"/>	<input type="radio"/>
Eye Problems/Vision Loss	<input type="radio"/>	<input type="radio"/>	Nose Fracture	<input type="radio"/>	<input type="radio"/>
Injury to the Spleen	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Joint Sprain/Ligament Tear/Muscle Pullo	<input type="radio"/>	<input type="radio"/>	Stomach Ulcer	<input type="radio"/>	<input type="radio"/>

Yes No

- Is there a current medical examination on file in the nurse's office:  Yes  No
- Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education?  Yes  No
- Has your child been unconscious or lost memory from a blow on the head?  Yes  No

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes	<input type="radio"/>	<input type="radio"/>
Severe hearing loss in both ears.	<input type="radio"/>	<input type="radio"/>
One kidney	<input type="radio"/>	<input type="radio"/>
One testicle	<input type="radio"/>	<input type="radio"/>
Has your child been ill for five (5) consecutive days?	<input type="radio"/>	<input type="radio"/>
Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice? _____	<input type="radio"/>	<input type="radio"/>

Is your child under medical care now?  YES  NO

Has your child taken any medication in the past year?  YES  NO

Is your child taking any medications now?  YES  NO

If so, why? \_\_\_\_\_

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Has your child ever fainted during exercise?  YES  NO

If so, explain. \_\_\_\_\_

Has there ever been sudden death in a family member under fifty (50) years of age?  YES  NO

Do you have any worries about your child's health or other questions you would like to discuss with a doctor?  YES  NO

Does your child have: orthodontic appliances?  YES  NO

Capped teeth?  YES  NO

Wear contact lenses for sports?  YES  NO

Wear glasses for sports?  YES  NO

Since your child's last physical examination, has your child had any injury or illnesses?  YES  NO

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designed by school authorities.

PARENT SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_

*(Continued on next page)*

with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays,

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ authorize my child's healthcare provider(s) listed below to release my child's \_\_\_\_\_ medical records to the district's medical officer, physical (PT), occupational (OT), speech therapists (ST) and/or school nurse:

Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

The healthcare provider may disclose the following protected health information: (check all that apply)

- Immunizations
- Health Appraisals
- Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST needs
- Other

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery and/or therapy prescriptions for PT, OT, ST
- At patient's request with no specified purpose
- Other

Please select one:

- This authorization is valid for the entire academic school year 20\_\_ - 20\_\_
- This authorization shall expire on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

\_\_\_\_\_  
\_Date Signature of Patient (Over 18), Parent, or Guardian Relationship

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

: A signed copy of this authorization must be given, to the adult patient or parent of the minor child