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:** _____

Port Byron Central 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: _____ HR_____ Urine: ☐Negative ☐ Positive 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:** _____

☐ **Known or suspected disability:** _____

☐ **Restrictions:** _____

☐ **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. *Rev. 6/12*

STUDENT NAME: _____ GRADE: _____

PARENT/GUARDIAN: _____ PHONE: HOME _____ WORK _____

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN NAME: _____ PHONE: _____

DATE OF LAST TETANUS SHOT: _____

TO PARENT OR GUARDIAN:

Participation in athletics is voluntary and is not a required part of the regular physical education program. All athletes must have a sports physical by our school physician or present a physical from your private physician to our school doctor for his approval (New York State Department of Education Mandate). No student may participate in a school sport without an approved physical and health history.

THIS FORM MUST BE COMPLETED AND RETURNED ON OR BEFORE THE DAY THE ATHLETE HAS HIS/HER PHYSICAL.

Has your child ever had: (please check and provide details i.e., date, treatment prescribed, Physician's Name, current status of the problem etc.) If medication is prescribed as necessary when symptom arises, parent and physician must sign Medication Authorization form.

Does your child have any of the following?

	YES	NO		YES	NO
Allergies/Hay Fever	____	____	Elevated Blood Pressure	____	____
Bee Sting Allergy	____	____	Headaches	____	____
Asthma	____	____	Head Injury/Concussion	____	____
Anemia	____	____	Heart Problem/Murmur-Chest Pain	____	____
Arthritis	____	____	Nose Bleeds/Frequent or Severe	____	____
Bladder/Kidney Problems or Injury	____	____	Ankle Injury	____	____
Convulsions/Seizures	____	____	Back Pain/Injury	____	____
Fainting Spells	____	____	Fracture-Dislocation Bones/Joints	____	____
Diabetes	____	____	Knee Pain/Injury	____	____
Ear Problems/Hearing Loss	____	____	Neck Injury	____	____
Eye Problems/Vision Loss	____	____	Nose Fracture	____	____
Injury to the Spleen	____	____	Rheumatic Fever	____	____
Joint Sprain/Ligament Tear/ Muscle Pull	____	____	Stomach Ulcer	____	____
One Testicle	____	____	Rapid Heartbeat	____	____
One Kidney	____	____	Ill for 5 consecutive days	____	____
Hospitalization	____	____	Frequent absences or lateness	____	____
Emergency Room Visit	____	____	Sudden Death of Family Member under fifty years of age?	____	____
Present Illness	____	____	Orthodontic Appliance	____	____
Daily Medication	____	____	Capped Teeth	____	____
On Medication Now	____	____	Contact Lens	____	____
Fainted During Exercise	____	____	Glasses for Sports	____	____

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 athletic contest, as well as the mandated physical clearance by our school doctors.

I understand that I am responsible for medical care for accident/injury. The school does not provide insurance coverage.

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

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

FORM HH