HEALTH CERTIFICATE / APPRAISAL FORM

Name: ____ **Date of Birth:** ___________ **Date of Exam:** ___________

School: ____ **Gender:** Male_____ Female______ **Grade:**_________________

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached ❒Dental Referral ❒Yes ❒ No ❒Not done Date_________

❒ Immunizations given since last Health Appraisal: ❒ Elevated Lead ❒Yes ❒ No ❒Not done Date__________

Significant Medical/Surgical History

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: ____

Surgeries/Date:____

____

Allergies: ❒ **LIFE THREATENING** ❒ Food: ______________ ❒ Insect: ______________________ ❒ Other: _____________________________

❒ Seasonal ❒ Medication: ____

MEDICATIONS

Medications (list all): ❒ None

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 EXAM

Height: _______________ Weight: _______________ Blood Pressure: _______________ Pulse: _____________

Body Mass Index: _____ _____. _____					*Referral*
Weight Status Category (BMI Percentile):	Vision - without glasses/contact lenses	R	L		
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - with glasses/contact lenses	R	L		
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Vision - Near Point	R	L		
	Hearing ❑ Pass 20 db sc both ears or:	R	L		

❒ **Tanner: I. II. III. IV. V.** **Scoliosis:** ❒ **Negative** ❒ **Positive: ______________**

❒ **FEMALE TRIAD SCREENING ___ Negative ___ Positive (specify ___ disordered eating ___ amenorrhea ___ osteoporosis)**

Date of Last Menses __________ Further Evaluation Needed ________________________________

☐ **EXAM ENTIRELY NORMAL Specify** any abnormality____

____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❒ **Free from contagions & physically qualified for all physical education, sports, and playground and 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, weight train, crew, dance, track, run, walk, rope jump.

❒ **Working Papers: Physically qualified for lawful employment.**

❒ **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: _____________________________

Provider's Signature: ____ Phone: _______________________________ (Stamp below)

Provider's Name/Address: ____ Fax: ________________________________

NORTH SYRACUSE CENTRAL SCHOOLS—PHYSICAL FORM

PARENT/GUARDIAN: COMPLETE HEALTH HISTORY **PHYSICIAN**: COMPLETE BACK OF FORM
PHYSICAL EXAMINATION IS VALID FOR ONE YEAR. **SPORT:____________________**

STUDENT NAME____ M___F___SCHOOL_________________GRADE______
ADDRESS____PHONE____________________________D.O.B.________
MOTHER/GUARDIAN____PHONE(W)_____________________CELL_______________
FATHER/GUARDIAN____PHONE(W)____________________CELL______________
FAMILY PHYSICIAN____PHONE____

HEALTH HISTORY

GENERAL	NO	YES—PLEASE EXPLAIN !
1. Has your child had a medical illness or injury since the last check up or sports physical?	__	______________________
2. Has your child been diagnosed with a blood or bleeding disorder?	__	______________________
3. Has your child ever had surgery?	__	______________________
4. Is your child currently taking any medication—prescription or “over the counter”?	__	______________________
5. Does your child have any allergies (i.e.—to pollen, medicine, food, stinging insects)?	__	______________________
6. Has your child ever had a rash or hives develop during or after exercise?	__	______________________
7. Does your child use any special protective or corrective equipment for sports?	__	______________________
EYES / EARS / DENTAL		
1. Does your child have one eye or severe uncorrectable vision in one or both eyes?	__	______________________
2. Does your child wear contacts or glasses?	__	______________________
3. Does your child have a hearing / ear problem?	__	______________________
4. Does your child have dental health problems or wear a dental appliance?	__	______________________
RESPIRATORY		
1. Does your child have asthma or a lung disease?	__	______________________
2. Does your child have seasonal allergies that require medical treatment?	__	______________________
3. Does your child use an inhaler?	__	______________________
4. Has your child been exposed to or treated for tuberculosis?	__	______________________
CARDIOVASCULAR		
1. Has your child ever had chest pain during or after exercise?	__	______________________
2. Has your child ever been treated for anemia?	__	______________________
3. Does your child have a heart murmur or other cardiac condition?	__	______________________
4. Do you have a family cardiac history of death before the age of 40?	__	______________________
5. Has your child had high or low blood pressure?	__	______________________
MUSCULOSKELETAL		
1. Has your child broken any bones, dislocated any joints or had a stress fracture?	__	______________________
2. Has your child had a strain, sprain, or swelling that has kept them from participating in any athletic activities?	__	______________________
3. Does your child have scoliosis?	__	______________________
GENITOURINARY		
1. Has your child ever had a hernia?	__	______________________
2. Does your child have kidney disease or only one kidney?	__	______________________
3. Males only: does your son have only one testicle?	__	______________________
4. Females only: has there been a recent change in menstrual patterns?	__	______________________
NEUROLOGICAL		
1. Has your child ever had a seizure or convulsion?	__	______________________
2. Has your child ever had a head injury or concussion?	__	______________________
3. Has your child ever been dizzy or fainted?	__	______________________
GASTROINTESTINAL / METABOLIC / ENDOCRINE		
1. Has your child been diagnosed with any chronic GI problem (i.e.-colitis, Crohns, ulcers)?	__	______________________
2. Has your child ever had high or low blood sugar or been diagnosed with Diabetes?	__	______________________
3. Has your child been diagnosed with high or low thyroid levels?	__	______________________
OTHER—Does your child receive treatment for any other condition not listed?	__	______________________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian____Date_______________