EASTCHESTER UNION FREE SCHOOL DISTRICT

(914) 793-6130

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:** ________________________

IMMUNIZATIONS / HEALTH HISTORY

❑ **Immunization record attached** **PPD**: ❑ Positive ❑Negative ❑ Not at Risk MD Signature__________ Date: ________

❑ No immunizations given today Chest X-Ray ❑ Positive ❑Negative ❑ Not done Date: ________

❑ Immunizations given since last Health Appraisal: Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: ________

Dental Referral ❑ Yes ❑ No ❑ Not done Date: ________

Significant Medical/Surgical History: ❑ See attached ________________________

Specify current medical conditions: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hypertension
❑ Other: ________________________

Allergies: ❑ **LIFE THREATENING** ❑ Food: ________ ❑ Insect: ________ ❑ Other: ________

❑ Seasonal ❑ Medication: ________________________

PHYSICAL EXAM

Date of Exam: ________ Height: ________ Weight: ________ Blood Pressure: ________

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	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❑ **EXAM ENTIRELY NORMAL**

❑ **TANNER**: I. II. III. IV. V.

❑ **SCOLIOSIS**: ❑ Negative ❑ Positive: ________________

MEDICATIONS

Medications (list all) including Over the Counter meds (OTC's) ex. Tylenol, Ibuprofen ❑ None ❑ Additional medications listed on reverse of form

Name: ________________________ Dosage/Time: ________________________

Name: ________________________ Dosage/Time: ________________________

Name: ________________________ Dosage/Time: ________________________

I assess this student to be self-directed ❑ Yes ❑ No Student may self carry and self administer medication ❑ Yes ❑ No

NOTE: Parent MUST sign below in order for prescribed meds to be given and for student to self-administer. Nurse will also assess self-direction for the school setting.

Parent is responsible for providing all medication, including OTC's, in its original container and properly labeled with student's name.

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

❑ **Physically qualified for all activities. No limitations (OR only as checked):**

___ Limited activity: Specify Activity allowed. ________________________

___ No Activity. Reason________________________

❑ **Specify medical accommodations needed for school**: ________________ ❑ None

❑ **Known or suspected disability:** ________________ ❑ Please monitor

❑ **Restrictions:** ________________ ❑ Please monitor

❑ **Protective equipment required:** ❑ Specify: ________________

Physician's Name/Address: ________________ Phone:__________ License No.__________

Physician's Signature: ________________ Fax: ________________

Parent Signature: (includes medication consent) ________________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. 9/21/11*