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

☐ Immunization record attached
☐No immunizations given today
☐Immunizations given since last health appraisal

Sickle Cell Screen: ☐ Positive ☐ Neqative ☐ Not done Date:__________
PPD: ☐ Positive ☐ Neqative ☐ Not done Date:__________
Elevated Lead: ☐ Positive ☐ Neqative ☐ Not done Date:__________
Dental Referral ☐ Positive ☐ Neqative ☐ 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:____________________

Weight Status Category (BMI Percentile):
☐ less than 5th ☐5th through 49th ☐ 50th through 84m
☐ 85th through 94"1 ☐ 95th through 98th ☐ 99th and higher

	R	L	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 (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:__________

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. 2/*

Physical will be conducted on: Grade________

Date____________________

Time____________________

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	○	○	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 Problem 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 Pullo	○	○	Stomach Ulcer	○	○

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

History Continued

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes	o	o
Severe hearing loss in both ears.	o	o
One kidney	o	o
One testicle	o	o
Has your child been ill for five (5) consecutive days?	o	o
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?________________	o	o
Is your child under medical care now?	o	o
Has your child taken any medication in the past year?	o	o
Is your child taking any medications now?	o	o

If so, why?____

____

____

Has your child ever fainted during exercise?	o	o

If so, explain.____

Has there ever been sudden death in a family member under fifty (50) years of age?	o	o
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?	o	o
Does your child have: orthodontic appliances?	o	o
Capped teeth?	o	o
Wear contact lenses for sports?	o	o
Wear glasses for sports?	o	o
Since your child's last physical examination, has your child had any injury or illnesses?	o	o

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)

Your healthcare provider will require the release of information form below to share Protected Medical Information

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