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: _____

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

❒ **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