

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 done 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	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> 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: \_\_\_\_\_