WAPPINGERS CENTRAL SCHOOL DISTRICT - HEALTH EXAMINATION CERTIFICATE

School: _____ Gender: ☐ M ☐ F Grade: _____ Today's Date_____

Student Name: _____ Date of Birth: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Specify current diseases: ☐ Asthma ☐ Seizures Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
Other: _____

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 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

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: _____

Student May Participate in Routine School Activities ☐ Yes ☐ No Student Is Free Of Communicable Diseases ☐ Yes ☐ No

Specify any abnormality _____

Significant Abnormal Physical Exam Findings _____

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, the parent/guardian must call the School Nurse so that the dose may be given at school: ☐ Yes
I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No

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

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
☐ Contact/Collision (Football, Baseball, Basketball, Soccer, Field Hockey, Wrestling, Lacrosse, Softball)
☐ Endurance Activities (Gymnastics, Swimming, Track, Cross Country, Volleyball)
☐ Others (Bowling, Golf, Field Events, Cheerleading)
☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____

☐ **Limitations/Restrictions:** _____

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

Please Attach An Updated Copy Of The Student's Immunization Record

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). This exam complies with NYSED requirements 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.

WAPPINGERS CENTRAL SCHOOL DISTRICT

Dear Parent/Guardian:

New York State Education Law requires that a Health Certificate be furnished for new entrants, students in grades K, 2, 4, 7 and 10, sports, working permits and triennially for the committee on Special Education (CSE).

Since your family physician has a more complete understanding of your child's health, we respectfully urge you to take your child to your family physician for a physical examination and have the HEALTH EXAMINATION CERTIFICATE on the back of this form completed and returned to your child's school health office by October.

Physical examinations are good for one year from the date that they are given and remain so until the last day of the month in which they were given

If you do not wish to have your family physician perform this examination, or if the record of examination is not received by the school's health office, your child will be scheduled to be examined by the school physician/associate.

HEALTH HISTORY

	DATE		DATE
Chicken Pox		Pneumonia	
Ear Infection		Strep Throat	
Hepatitis		Scarlet Fever	
Meningitis		Rheumatic fever	
Tuberculosis		Mononucleosis	

Please list all allergies your child has _____

_____

Please list any recent injuries, illnesses and/or surgeries _____

_____

Please note any other health problem not listed above _____

_____

I will notify the School Nurse of any changes in my child's health status or an absences of more than 5 days.

_____ _____

Parent/Guardian Signature Date

See Other Side