

WAPPINGERS CENTRAL SCHOOL DISTRICT - HEALTH EXAMINATION CERTIFICATE

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____ Today's Date: _____

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 Other: _____
 Hyperlipidemia Hypertension

Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____ Referral

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

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

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: _____

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 / 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

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