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).

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 Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Seizures 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: ___ ___ . ___	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ 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 (use 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 / 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

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.

6/11

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

6/11