HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____ **Date of Exam:** _____

School: _____ **Gender:** Male_____ Female_____ **Grade:**_____

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached ❒Dental Referral ❒Yes ❒ No ❒Not done Date_____

❒ Immunizations given since last Health Appraisal: ❒ Elevated Lead ❒Yes ❒ No ❒Not done Date_____

Significant Medical/Surgical History

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

Surgeries/Date:_____

_____

Allergies: ❒ **LIFE THREATENING** ❒ Food: _____ ❒ Insect: _____ ❒ Other: _____

❒ Seasonal ❒ Medication: _____

MEDICATIONS

Medications (list all): ❒ None

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 EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

				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	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **Tanner: I. II. III. IV. V.** **Scoliosis: ❒ Negative ❒ Positive:** _____

❒ **FEMALE TRIAD SCREENING ___ Negative ___ Positive (specify ___ disordered eating ___ amenorrhea ___ osteoporosis)**

Date of Last Menses _____ Further Evaluation Needed _____

☐ **EXAM ENTIRELY NORMAL Specify** any abnormality_____

_____

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

❒ **Free from contagions & physically qualified for all physical education, sports, and playground and school activities OR only as checked:**

___ **Limited** contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, weight train, crew, dance, track, run, walk, rope jump.

❒ **Working Papers: Physically qualified for lawful employment.**

❒ **Specify medical accommodations needed for school**: _____ ❒ None

❒ **Known or suspected disability:** _____ ❒ Please monitor

❒ **Restrictions:** _____ ❒ Please monitor

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

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

Provider's Name/Address: _____ Fax: _____

NORTH SYRACUSE CENTRAL SCHOOLS—PHYSICAL FORM

PARENT/GUARDIAN: COMPLETE HEALTH HISTORY **PHYSICIAN**: COMPLETE BACK OF FORM
PHYSICAL EXAMINATION IS VALID FOR ONE YEAR. **SPORT:_____**

STUDENT NAME_____ M___F___SCHOOL_____GRADE_____
ADDRESS_____PHONE_____D.O.B._____
MOTHER/GUARDIAN_____PHONE(W)_____CELL_____
FATHER/GUARDIAN_____PHONE(W)_____CELL_____
FAMILY PHYSICIAN_____PHONE_____

HEALTH HISTORY

	NO	YES—PLEASE EXPLAIN !
GENERAL		
1. Has your child had a medical illness or injury since the last check up or sports physical?	__	_____
2. Has your child been diagnosed with a blood or bleeding disorder?	__	_____
3. Has your child ever had surgery?	__	_____
4. Is your child currently taking any medication—prescription or "over the counter"?	__	_____
5. Does your child have any allergies (i.e.—to pollen, medicine, food, stinging insects)?	__	_____
6. Has your child ever had a rash or hives develop during or after exercise?	__	_____
7. Does your child use any special protective or corrective equipment for sports?	__	_____
EYES / EARS / DENTAL		
1. Does your child have one eye or severe uncorrectable vision in one or both eyes?	__	_____
2. Does your child wear contacts or glasses?	__	_____
3. Does your child have a hearing / ear problem?	__	_____
4. Does your child have dental health problems or wear a dental appliance?	__	_____
RESPIRATORY		
1. Does your child have asthma or a lung disease?	__	_____
2. Does your child have seasonal allergies that require medical treatment?	__	_____
3. Does your child use an inhaler?	__	_____
4. Has your child been exposed to or treated for tuberculosis?	__	_____
CARDIOVASCULAR		
1. Has your child ever had chest pain during or after exercise?	__	_____
2. Has your child ever been treated for anemia?	__	_____
3. Does your child have a heart murmur or other cardiac condition?	__	_____
4. Do you have a family cardiac history of death before the age of 40?	__	_____
5. Has your child had high or low blood pressure?	__	_____
MUSCULOSKELETAL		
1. Has your child broken any bones, dislocated any joints or had a stress fracture?	__	_____
2. Has your child had a strain, sprain, or swelling that has kept them from participating in any athletic activities?	__	_____
3. Does your child have scoliosis?	__	_____
GENITOURINARY		
1. Has your child ever had a hernia?	__	_____
2. Does your child have kidney disease or only one kidney?	__	_____
3. Males only: does your son have only one testicle?	__	_____
4. Females only: has there been a recent change in menstrual patterns?	__	_____
NEUROLOGICAL		
1. Has your child ever had a seizure or convulsion?	__	_____
2. Has your child ever had a head injury or concussion?	__	_____
3. Has your child ever been dizzy or fainted?	__	_____
GASTROINTESTINAL / METABOLIC / ENDOCRINE		
1. Has your child been diagnosed with any chronic GI problem (i.e.-colitis, Crohns, ulcers)?	__	_____
2. Has your child ever had high or low blood sugar or been diagnosed with Diabetes?	__	_____
3. Has your child been diagnosed with high or low thyroid levels?	__	_____
OTHER—Does your child receive treatment for any other condition not listed?	__	_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian_____Date_____