

RAVENA-COEYMANS-SELKIRK CENTRAL SCHOOLS HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

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: _____

Significant Medical/Surgical History: See attached _____

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

PHYSICAL EXAM

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

SKIN _____
 HEENT _____
 TEEETH/GUMS _____
 LYMPH/THYROID _____
 CARDIOVASCULAR _____
 RESPIRATORY _____

ABDOMEN _____
 MUSCULOSKELETAL _____
 NERVOUS SYSTEM _____
 HERNIA _____
 GENITO-URINARY _____
 URINALYSIS _____

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

Specify any abnormality (use reverse of form if needed): _____

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____ at school? Yes ___ No ___

Name: _____ Dosage/Time: _____ at school? Yes ___ No ___

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 of emergency.

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:

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

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: _____

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

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

Provider's Name/Address: _____ Phone: _____

Parent Signature: _____ Date: _____