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).

SMITHTOWN CENTRAL SCHOOL DISTRICT

HEALTH CERTIFICATE / APPRAISAL FORM / PHYSICAL FORM

sport_____

To parents of students who are participating in sports: Please complete the health history form and bring it with you to your student's physician in addition to this form.

To all parents: Make sure you sign the back of this form and the medication section if your student is taking any medications during the school day or during sports.

To Physicians: Please complete both sides of this form, sign and stamp.

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

School: _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached (see back of form) Dental Referral: Yes _____ No _____ Not Done _____Date: _____

❒ No immunizations given today

❒ Immunizations given since last Health Appraisal:

Significant Medical/Surgical History: ❒ See attached _____

_____

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

❒ Seasonal ❒ Medication: _____

OPTIONAL INFORMATION, if known

Specify current diseases**:** ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2

❒ Hyperlipidemia ❒ Hypertension

❒ Other: _____

PHYSICAL EXAM

Date of Exam: _____Height: _____ Weight _____ Blood Pressure_____ Urine: Prot: ____ Glucose____

Weight Status Category (BMI Percentile): _____						Referral
❑ less than 5th	❑ 5th through 49th	❑ 50th through 84th	Vision without correction ❑	R	L	
			Vision with correction ❑	R	L	
			Vision - Near Point	R	L	
❑ 85th through 94th	❑ 95th through 98th	❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

Ears: _____ Eyes: _____ Nose: _____

Lymph nodes: _____ Thyroid: _____ Tonsils: _____

Teeth: _____ Heart: _____ Lungs: _____

Genito-Urinary: _____ Hernias: _____ Skin: _____

Epilepsy: _____ Speech: _____ Nutrition: _____

Nervous System: _____ Other: _____

Orthopedic-Structural-Postural-Feet: _____

Scoliosis: ❒ Negative ❒ Positive: _____

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

_____

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V.

PLEASE COMPLETE PAGE 2

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. *Rev. 2/08*

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MEDICATIONS

Medications (list all) to be taken during school hours: ❒ None ❒ List additional medications on an attached sheet

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
PARENT SIGN HERE IF YOU AGREE THAT YOUR STUDENT MAY SELF CARRY AND SELF ADMINISTER THEIR MEDICATION:
_____ (make sure all medications are clearly labeled with student's name in original container)
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

THIS FORM AND THE HEALTH HISTORY FORM MUST BE COMPLETED AND RETURNED TO THE HEALTH OFFICE TO BE CLEARED FOR SPORTS PARTICIPATION.

❒ **CONTACT SPORTS:** Free from contagions & physically qualified for all physical education, sports (including contact sports i.e. football, wrestling, basketball, soccer, lacrosse, field hockey, softball, baseball)

❒ **LIMITED CONTACT**: cheerleading, gymnastics, volleyball, cross-country, handball, baseball, floor hockey.

❒ **NON-CONTACT**: badminton, bowling, golf, swim, table tennis, tennis, archery, weight train, dance, track and field, run, walk, rope jump.

❒ **PHYSICAL EDUCATION ACTIVITIES ONLY**

❒ Specify medical accommodations needed for school: _____ ❒ None

❒ Known or suspected disability: _____

❒ Restrictions: _____

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

Immunization History:

MMR: Date: _____ Date: _____

Measles: Date: _____ Date: _____ Mumps: Date: _____ Rubella: Date: _____

Varivax: Date: _____ Date: _____ or Date of Disease: _____

DPT: Date: _____ Date: _____ Date: _____ Boosters: _____, _____, _____

Tdap: Date: _____

POLIO: Date: _____ Date: _____ Date: _____ Boosters: _____, _____, _____

HEP B: Date: _____ Date: _____ Date: _____

HEP A: Date: _____ Date: _____

HIB: Date: _____ Date: _____ Date: _____ Date: _____

Meningococcal: Date: _____

Guardasil: Date: _____ Date: _____ Date: _____

TB: Date: _____ Results: _____ Other: _____

PHYSICIAN'S SIGNATURE: _____

Physician's phone: _____ Fax _____

Parent Signature: _____ Date: _____

Signature of School District Medical Officer: _____ Date: _____

PHYSICIAN'S STAMP

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