MONROE-WOODBURY CENTRAL SCHOOL DISTRICT

EDUCATION CENTER, 278 ROUTE 32, CENTRAL VALLEY, NEW YORK

HEALTH CERTIFICATE/APPRAISAL FORM

NYSED requires an annual physical exam for new entrants, students, in Grade K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

Name:_____Date of Birth:_____

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

IMMUNIZATION/HEALTH HISTORY

❑Immunization record attached ❑No immunizations given today

❑Immunizations given since last Health Appraisal:_____

Significant Medical/Surgical History: ❑See Attached_____

A**llergies:** ❑**LIFE THREATENING** ❑Food:_____ ❑Insect:_____ ❑Other:_____

❑Seasonal:_____ ❑Medication:_____

Specify current diseases: ❑Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension

❑Other:_____

PHYSICAL EXAM

Blood Pressure: _____ Pulse:_____ Scoliosis: ❑ Negative ❑ Positive _____

Tanner: I. II. III. IV. V.

Height: _____ Weight: _____ Body Mass Index: ____ ____ . ____ Weight Status Category (BMI Percentile): ❑less than 5th ❑5th – 49th ❑50th – 84th ❑85th – 94th ❑95th – 98th ❑99th and higher		Right	Left	Referral
	Vision - without glasses/contact lenses Vision - with glasses/contact lenses Hearing ❑ Pass 20db sc both ears or:			

❑ **EXAM ENTIRELY NORMAL**

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

MEDICATIONS

Medications (list all) ❑ None ❑ Additional medications listed on reverse side

Name:_____ Dosage/Time:_____

Name:_____ Dosage/Time:_____

If AM dose is missed at home:_____ Student may self-carry and self-administer medication ❑Yes ❑No

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATIONS/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, baseball, floor hockey, softball.

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

❑ Specify medical accommodations needed for school:_____ ❑ None

❑ Known or suspected disability:_____ ❑ Please Monitor

❑Restriction:_____ ❑ Please Monitor

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

Date of Exam: _____ (Stamp Below)

Provider's Signature _____

Providers Name/Address: _____

_____

Phone #:_____ Fax #:_____