Nyack Public Schools
ANNUAL HEALTH CERTIFICATE

NAME_____ **AGE**_____ **DOB** _____
PLEASE PRINT LAST NAME FIRST NAME

GRADE _____ **PARENT/GUARDIAN SIGNATURE**_____

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE SECTIONS BELOW & ATTACH A COPY OF THE MOST RECENT IMMUNIZATION RECORD TO THIS FORM

HEIGHT: _____ WEIGHT: _____ BMI _____ BMI %____ **REQUIRED BY NY STATE**

ALLERGIES: ❑ None known ❑ Yes-Please list all: _____

HEART: ❑ SiS2 ❑ Other_____ ❑ Murmur **B/P: I** **(REQUIRED FOR SPORT CLEARANCES)**

LUNGS: ❑ CTA ❑ Other_____ ❑ Asthma: ❑ Inhaler

SKIN: ❑ WNL ❑ Other _____ MOUTH/THROAT: ❑ WNL ❑ Other _____

EYES: 0 WNL ❑ Other _____ Vision R ___/ Vision L _____/ ❑ Glasses/Contacts

EARS: 0 WNL ❑ Other Hearing Screen results: R ear-ISO _____ L ear-ISO _____

G/U: ❑ WNL ❑ Other _____ **URINALYSIS: Date o WNL Other** _____
REQUIRED FOR SPORT CLEARANCES

G/I: ❑ WNL ❑ Other_____ NUTRITIONAL STATUS: ❑ WNL ❑ Other _____

MUSCULO-SKELETAL: ❑ WNL ❑ Other _____ ROM: ❑ WNL ❑ Other ___

Scoliosis: _____ Hernia: _____

NEURO: ❑ WNL ❑ Other _____ ❑ Seizure Hx - ❑ Medication _____

Referral by MD for medical follow-up: _____

List any significant medical problems, illnesses, accidents or surgeries:

_____

Should this student's school program be modified in any way? ❑ No ❑ Yes, explain:

_____

Is this student on medication? ❑ No ❑ Yes- List drug, dosage and frequency:

_____

Date of Exam: _____ Signature of Physician: _____ MD Stamp: