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**_____ **Percentile** _____ **REQUIRED BY NY STATE**

ALLERGIES: □ None known □ Yes-Please list all:_____
If yes, MD please complete Allergy Action Plan

HEART: □ S_1S_2 □ Other_____ □ Murmur **B/P:** ____/_____ **(REQUIRED FOR SPORT CLEARANCES)**

LUNGS: □ CTA □ Other_____ASTHMA: □ No □ Yes → □ **Inhaler** - _____
If yes, MD please complete Asthma Action Plan

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

EYES: □ WNL □ Other _____ Vision R ____/_____ Vision L _____/_____ □ Glasses/Contacts

EARS: □ WNL □ Other _____ Hearing Screen results: R ear-ISO_____ L ear-ISO_____

G/U: □ WNL □ Other _____ **URINALYSIS: Date _____ □ 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 any medication? □ No □ Yes – List drug, dosage & frequency: _____

_____

Date of exam: ___/___/___ Signature of Physician: _____ MD Stamp: