NYACK PUBLIC SCHOOLS

ANNUAL HEALTH CERTIFICATE

NAME _____, _____ AGE_____ DOB____/____/____
PLEASE PRINT LAST NAME FIRST NAME

ADDRESS _____ 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 %** ____ **ALLERGIES:** _____
REQUIRED BY NY STATE

HEART: □ S_1S_2 □ Other_____ □ Murmur_____ □ Regular □ Irregular _____

Rate: _____ **B/P:** _____/_____ **REQUIRED FOR SPORT CLEARANCES**

LUNGS: □ CTA □ Other_____ □ Asthma: □ **Inhaler** - _____

SKIN: □ WNL □ Other _____ LYMPH NODES: □ WNL □ Other _____

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

TONSILS: □ WNL □ Other _____ TEETH: □ WNL □ Other _____

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

EARS: □ WNL □ Other _____ Any known hearing loss _____

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 _____

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: _____

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