

REQUIRED for NEW ENTRY, KINDERGARTEN and GRADES 2, 4, 7 & 10

A current physical is also required sport participation

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: S₁S₂ 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 _____

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: _____