

## HEALTH CERTIFICATE / APPRAISAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached  
 No immunizations given today  
 Immunizations given since last Health Appraisal:

Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
 PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Elevated Lead:  Yes  No  Not done Date: \_\_\_\_\_  
 Dental Referral  Yes  No  Not done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Vision - without glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td style="text-align: center;">Referral</td> </tr> <tr> <td style="text-align: center;">Vision - with glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Vision - Near Point</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> </table>	Vision - without glasses/contact lenses	R	L	Referral	Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
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EXAM ENTIRELY NORMAL    Tanner: I. II. III. IV. V.    Scoliosis:  Negative  Positive: \_\_\_\_\_

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

### MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed  Yes  No    Student may self carry and self administer medication  Yes  No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / 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, fence, baseball, floor hockey, softball.  
 \_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: \_\_\_\_\_  None

Known or suspected disability: \_\_\_\_\_  Please monitor

Restrictions: \_\_\_\_\_  Please monitor

Protective equipment required:  Athletic Cup  Sport goggles/impact resistant eyewear  Other: \_\_\_\_\_

### OPTIONAL INFORMATION, if known

Specify current diseases:  Asthma    Diabetes:  Type 1  Type 2     Hyperlipidemia     Hypertension  
 Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)

Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_