# NORTHERN ADIRONDACK CENTRAL HIGH SCHOOL
# HEALTH CERTIFICATE / APPRAISAL FORM

**Parents, please fill in Health History & Medication sections.**
**Sign & return to Health Office.**

**Name:** _____ **Date of Birth:** _____

**Gender:** ❑ **M** ❑ **F** **Grade:** _____

## IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached or in Health Record

❒ Immunizations given since last Health Appraisal: _____

Sickle Cell Screen: ❒ Positive ❒ Negative ❒ NA
PPD: ❒ Positive ❒ Negative ❒ NA
Elevated Lead: ❒ Yes ❒ No ❒ NA
Dental Referral ❒ Yes ❒ No ❒ NA

**Significant Medical/Surgical History**: ❒ **Specify current diseases:** _____
❒ **Surgeries:**_____❒ Asthma ❒ Diabetes: ❒ Hypertension

**Allergies**: ❒ **LIFE THREATENING** ❒ Food: _____ ❒ Insect: _____ ❒ Seasonal _____❒ Other: _____

❒ Medication: _____

## PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ H.R._____ Date of Exam: _____

| | | | | *Referral* |
|---|---|---|---|---|
| Body Mass Index: ____ ____ . ____ | Vision - without glasses/contact lenses | R | L | |
| Weight Status Category (BMI Percentile): | Vision - with glasses/contact lenses | R | L | |
| ❑ less than 5th ❑ 5th -- 49th ❑ 50th -- 84th | Vision - Near Point Color_____ | R | L | |
| ❑ 85th -- 94th ❑ 95th -- 98th ❑ 99th and higher | Hearing ❑ Pass 20 db sc both ears or: | R | L | |

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V.

HEENT:_____NECK:_____CHEST:_____HEART:_____SKIN_____

**Scoliosis:** ❒ Negative ❒ Positive: Referral Requested_____

**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:_____

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 / 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, volleyball, cross-country, handball, baseball, floor hockey, softball, dodgeball.
___ Non-contact: badminton, bowl, golf, swim, tennis, weight train, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: _____ ❒ None

❒ **Restrictions:** _____ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Other: _____

Provider's Signature: _____ Date: _____

**Parent Signature:** _____Date: _____

NYSED requires an annual physical exam for new entrants, students in grades 7 & 10, sports, working permits, and triennially for the CSE.
This exam complies with the requirements and is valid for 12 months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider.