

HEALTH CERTIFICATE / APPRAISAL FORM

Rec'd _____
Appr _____

Name: _____ Date of Birth: _____
 School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

<input type="checkbox"/> Immunization record attached <input type="checkbox"/> No immunizations given today <input type="checkbox"/> Immunizations given since last Health Appraisal: _____	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____ Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____
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Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure/Pulse: _____ Date of Exam: _____
Referral

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Vision - without glasses/contact lenses</td> <td style="padding: 2px;">R</td> <td style="padding: 2px;">L</td> <td style="padding: 2px;"></td> </tr> <tr> <td style="padding: 2px;">Vision - with glasses/contact lenses</td> <td style="padding: 2px;">R</td> <td style="padding: 2px;">L</td> <td style="padding: 2px;"></td> </tr> <tr> <td style="padding: 2px;">Vision - Near Point</td> <td style="padding: 2px;">R</td> <td style="padding: 2px;">L</td> <td style="padding: 2px;"></td> </tr> <tr> <td style="padding: 2px;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="padding: 2px;">R</td> <td style="padding: 2px;">L</td> <td style="padding: 2px;"></td> </tr> </table>	Vision - without glasses/contact lenses	R	L		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	
Vision - without glasses/contact lenses	R	L															
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Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L															

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: _____