

NYSED requires an annual physical exam for new entrants, students in Grades Pre k or K, 1, 3, 5, 7, 9 & 11, sports, working permits and triennially for the Committee on Special Education (CSE)

**FRONTIER SCHOOLS 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: \_\_\_\_\_ HR \_\_\_\_\_ 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	
<input type="checkbox"/> less than 5 <sup>th</sup>	Vision - Near Point	R	L	
<input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup>	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
<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				

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, bowi, 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  Hypertension  Hyperlipidemia  
 Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)  
 Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_