

Hudson City School District

HEALTH CERTIFICATE / APPRAISAL FORM / PHYSICAL

Name: _____ Date of Birth: _____ 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:** Food: _____ Insect: Seasonal Medication: _____
- Other: _____
- Life Threatening Allergy Not a Life Threatening Allergy

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ . _____	Vision - without glasses/contact lenses	R	L	<i>Referral</i>
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	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: _____

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.

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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, rifle, 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:

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension

Other: _____

ADDITIONAL SPACE (IF NEEDED FROM FRONT):

Provider's Signature: _____

Phone: _____

Provider's Fax: _____

Provider's Name/Address (stamp below):

PLEASE FAX THIS FORM TO THE APPROPRIATE HEALTH OFFICE:

Hudson Jr./Sr. High School Fax Number: 518-697-8798

M.C. Smith Intermediate School Fax Number: 518-697-8797

John L. Edwards Primary School Fax Number: 518-697-8516