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

Smithtown Christian School

SPORT:_____
(Grades 7-12 only)

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

Date of Exam: _____ Height: _____ Weight: _____ Blood Pressure: _____ Urine: Prot.____ Glucose____

Body Mass Index: _____

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ 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): Healthcare provider to complete medication order form for each medication.

Name: _____ Name: _____

Name: _____ Name: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❑ Yes ❑ No
Note: Nurse will also assess self-direction for the school setting.

Student may self carry and self administer medication ❑ Yes ❑ No
Healthcare provider to complete Self Carry Form.

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: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 1/18

Smithtown Christian School
Health Screening/Medical History Form

It is the sole responsibility of the parent and/or guardian to furnish the Health Office with information regarding any change in the health status.

Name:_____**DOB:**___/___/____ **Grade:**_____

Sport:_____**School**_____

Parent/Guardian: Answer the following questions as accurately as possible with details if needed.

1. Has student suffered any head injuries/concussions with or without loss of consciousness during his/her lifetime? Yes/ No When? _____ Did loss of consciousness occur? Yes/ No
Describe event:_____
_____

2. Any broken bones, fractures, surgery? Yes/ No When?_____
Describe_____

3. Any other injury requiring medical attention/hospital visit? Yes/ No When?_____

Describe_____

4. History of heart murmur? Cardiac Arrhythmia? Palpitations? Yes/ No Describe_____

_____

5. Asthmatic? Yes/ No Requires an inhaler for sports/exercise? Yes/ No Describe_____
_____

6. Any other chronic diseases or ailments? Yes/ No Describe_____

_____

7. Any fainting/ dizziness/fatigue after exertion? Yes/ No Describe_____
_____

8. Taking Medications at this time? Yes/ No
Describe_____

9. Allergies? Yes/No (*Medications, foods, environment, etc.*)
Describe_____

10. Glasses/contact lenses: Yes/ No Protective eyewear needed? Yes/ No
Orthodontic appliance Yes /No

11. Any other conditions or impairment (*vision, speech, hearing, scoliosis, etc.*) that the health office should be aware of? Yes/ No
Describe_____

12. Any handicapped conditions or need for special services or therapy? Yes/ No
Describe_____

Parent or Guardian
signature:_____Date:_____

Revised 1/10/18