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: _____

				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 through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	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): ☐ 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