

IMMACULATE CONCEPTION SCHOOL

(914) 961-3785

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached PPD: Positive Negative Not done Date: _____

No immunizations given today Chest X-Ray: Positive Negative Not done Date: _____

Immunizations given since last Health Appraisal: Elevated Lead: Yes No Not done Date: _____

Dental Referral: Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Specify current medical conditions: Asthma Diabetes: Type 1 Type 2 Hypertension
 Other: _____

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

PHYSICAL EXAM

Date of Exam: _____ Height: _____ Weight: _____ Blood Pressure: _____ 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 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	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				

EXAM ENTIRELY NORMAL

TANNER: I. II. III. IV. V.

SCOLIOSIS: Negative Positive: _____

MEDICATIONS

Medications (list all) including Over the Counter meds (OTC's) ex. Tylenol, ibuprofen None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

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: Parent MUST sign below in order for prescribed meds to be given and for student to self-administer. Nurse will also assess self-direction for the school setting.

Parent is responsible for providing all medication, including OTC's, in its original container and properly labeled with student's name.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Physically qualified for all activities. No limitations (OR only as checked):
____ Limited activity: Specify Activity allowed. _____

____ No Activity. Reason _____

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Specify: _____

Physician's Name/Address: _____ Phone: _____ License No. _____

Physician's Signature: _____ Fax: _____

Parent Signature: (includes medication consent) _____ Date: _____