ROSS CORNERS
CHRISTIAN ACADEMY

HEALTH CERTIFICATE / APPRAISAL FORM

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).

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: _____ 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: _____

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, 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. 2/08 (Health Appraisal Form 208)

Sport Physical Health Form

Name of School Ross Corners Christian Academy **Date** _____

Health History Form for Sports Physicals for School Year _____ Current

Name _____ **Grade** _____ Current

Address _____ **Phone** _____

Birth Date _____ **Sport** _____

This form must be completely filled out, signed by your parents and submitted to the Health Office.

Medical Health History

1. **HAVE YOU HAD ANY OF THE FOLLOWING:**

	YES	NO	COMMENTS and DATES
a. Any injuries in past year			
1. Fractures			
2. Knee injuries/problems			
3. Ankle injuries/problems			
4. Shoulder injuries/problems			
5. Eye			
6. Concussion or history of concussion/head injury			
b. Serious illness or injury requiring hospitalization			
c. Hepatitis			
d. Infectious Mononucleosis (mono)			
e. Kidney/Problems/absence of one			
f. Visual Problems			
1. Blindness in one eye			
2. Detached retina			
3. Cataract			
g. Contacts (Soft, Hard) or Glasses			
1. Required?			
2. Wear for sports?			
h. Hearing impairment/problem			
i. Heart problems			
1. Congenital			
2. Heart murmur			
j. High blood pressure			
k. Shortness of breath/ chest pain when exerting/ asthma			
l. Light headed/dizzy spells			
m. Headaches			
n. Convulsions/epilepsy			
o. Allergies			
1. Medication			
p. Are you presently taking a medication? If yes, what is it?			

2. **DATE of LAST TETANUS BOOSTER** _____ (within the last ten years)

Parent's Signature _____ Student's Signature _____