RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
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

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

Heart: Organic: _____ Functional: _____ Normal Rate: _____

Exercise Test: 25 Hops on 1 foot (Rate): _____ After 2 minutes Rest: _____

Lymph: _____ Thyroid:_____ Liver: _____ Spleen:_____ Nervous System; _____

History of Concussions: #_____ Date(s): _____

				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: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

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.

Student Name: _____ Date of Exam: _____

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

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities**

❒ **Activity is limited, please check what student MAY do:**

CONTACT/COLLISION	LIMITED CONTACT/IMPACT	STRENUOUS NON-CONTACT	NON-STRENUOUS NON-CONTACT
( ) FIELD HOCKEY	( ) BASEBALL	( ) KICKBALL	( ) ARCHERY
( ) FOOTBALL	( ) BASKETBALL	( ) CROSS COUNTRY	( ) BOWLING
( ) FLOOR HOCKEY	( ) DIVING	( ) TRACK& FIELD	( ) GOLF
( ) LACROSSE	( ) GYMNASTICS	( ) SWIMMING	( ) ORIENTEERING
( ) SOCCER	( ) HANDBALL	( ) TENNIS	( ) BADMINTON
( ) WRESTLING	( ) ALPINE SKIING	( ) RUNNING	( ) JOGGING
	( ) CROSS-COUNTRY SKIING	( ) UPPER BODY EXERCISES	( ) WALKING
	( ) SOFTBALL	( ) LOWER BODY EXERCISES	( ) DANCE
	( ) VOLLEYBALL	( ) BIKING	( ) TABLE TENNIS
	( ) NERF DODGEBALL	( ) AEROBICS	( ) STRETCHING
	( ) CHEERLEADING		( ) FRISBEE

❒ **specify any medical accommodations needed for school:** _____

❒**known or suspected disability:** _____

❒ **Restrictions:** _____

❒**Protective equipment required:** ❒**Athletic Cup** ❒**Sports goggles/impact resistant eyewear** ❒ **Other** _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

❒**PCP Physical** ❒**School Physical** **FOR SCHOOL USE ONLY**

School Medical Director _____ Date: _____

Notes: _____

_____

This certificate is void if the student is absent form school for five (5) or more days because of illness or because of a significant injury/illness. A new certificate must be issued before he/she is allowed to participate. Anyone who chooses to go to their own family health care provider does at their own expense.

5/14