UNION FREE SCHOOL DISTRICT

■ HEATLY ELEMENTARY SCHOOL ■ HEATLY JR. - SR. HIGH SCHOOL

DR. MICHAEL MUGITS, *Superintendent*
ERIN L. PETEANI, *Principal*
MATTHEW J. ZEBROWSKI, *Asst. Principal*

171 HUDSON AVENUE, GREEN ISLAND, NEW YORK 12183
Phone: (518) 273-1422
Fax: (518) 270-0818

K-12 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: ________

Body Mass Index: ____ ____ . ____	Vision - without glasses/contact lenses	R	L	Referral
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)