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).

Irvington Union Free School District

Health Appraisal/Health Certificate

Dows Lane Health Office: 914-269-5150 (fax. 914-591-6863)
Main Street School Health Office: 914-269-5250 (fax. 914-591-3099)
Middle School Health office: 914-269-5350 (fax. 914-591-2643)
High School Health Office: 914-269-5450 (fax. 914-591-1956)

Name:____________________________ **Grade:** ________ **Date of Birth:**__________________ **Gender:** ❑ **M** ❑ **F**

IMMUNIZATIONS / HEALTH HISTORY

❑ **Immunization record attached (on back)**
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❑ Positive ❑Negative ❑ Not done Date: ___________
PPD: ❑ Positive ❑Negative ❑ **Not At Risk** Date: ___________
Elevated Lead: ❑ 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:** ______________

Weight Status Category: Grades K,2,4,7 and 10 required						*Referral*
❑ less than 5th	❑ 5th through 49th	❑ 50th through 84th	**Vision** - without glasses/contact lenses	R	L	
❑ 85th through 94th	❑ 95th through 98th	❑ 99th and higher	Vision - with glasses/contact lenses	R	L	
BMI:_______			Vision - Near Point	R	L	
			Hearing ❑ Pass 20 db sc both ears:	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 ❑ **May carry inhaler listed below**.

Name: ______________________________________ Dosage/Time: ______________________________

Name: ______________________________________ Dosage/Time: ______________________________

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: ___ Non-contact:

❑ **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 disease: ☐ **Asthma** **Diabetes:** ☐ **Type 1** ☐ **Type 2** ☐ **Hyperlipidemia** ☐ **Hypertension**

Provider's Signature______________________ Date____________ Phone: ________________

Provider's Name/Address: ______________________________ Fax: ________________

Parent Signature: ______________________________ Date: ________________

(Stamp below)

This exam complies with NYSED requirements and is valid for twelve months. *Rev. 5/7/17*