

WARWICK VALLEY CENTRAL SCHOOL DISTRICT
HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School Building: _____ 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: _____

If you have any objection to having this information shared with faculty and/or support staff in the form of a confidential list please sign here.

(signature)

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): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> 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

Please list any medications that this student is taking.

Any medication that is to be given during school hours must have a separate medication authorization form completed by the parent and prescriber.

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: _____

**HEALTH HISTORY
TO BE COMPLETED BY PARENT**

Has your child ever had: (Please check)

	YES	NO		YES	NO
Medication Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Injury to Spleen	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Fracture/of any bone	<input type="checkbox"/>	<input type="checkbox"/>
Bee sting Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Joint Dislocation/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ligament Injury	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Torn/Pulled Muscle	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Appliance	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds/freq. or severe	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Broken Nose	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	One Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	One Testicle	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems/Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Appliance	<input type="checkbox"/>	<input type="checkbox"/>
Vision in only one eye	<input type="checkbox"/>	<input type="checkbox"/>	Braces	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Capped Teeth/Bonded	<input type="checkbox"/>	<input type="checkbox"/>
Emergency room visit	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
Fainting during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Ill for 5 consecutive day	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/frequent or severe	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Absences/lateness	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Girls, Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	If yes, age started	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Heavy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Measles/German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations required?	<input type="checkbox"/>	<input type="checkbox"/>

If yes to the above questions, please provide details: dates, physician, treatment, current status of problem:

	YES	NO
Is your child under medical care now?	<input type="checkbox"/>	<input type="checkbox"/>
Is student on medication on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, medication and reason _____		

Did anyone in your immediate family below age 50 (fifty) die of a heart attack suddenly? YES NO

Has your child been unconscious or lost memory from a blow on the head? YES NO

Has your child ever had an illness, condition, or injury that required him/her to go the hospital either as a patient overnight or in the emergency room or for x-rays; or required an operation; or caused your child to miss school? YES NO

Is there any other information that the school should know in order to safeguard your child's health?

I understand that this confidential information will be shared with the school personnel deemed appropriate by the health professional in my child's building.

Parent/Guardian Signature: _____ Date: _____