HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:**

❒ 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: _____

School: Newcomb Central School **Gender:** ❑ **M** ❑ **F** **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

Significant Medical/Surgical History: ❒ See attached _____

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

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: _____

This exam complies with NYSED requirements 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*

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

_____ ❒ Please monitor

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

❒ **Restrictions:**

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

Provider's Name/Address: _ Fax: Parent Signature: _ Date:

_____

_____

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NEWCOMB CENTRAL SCHOOL
STUDENT HEALTH HISTORY

Name: _____ Age: Birthdate: _____

Address: _____ Phone Number: _____

Date of Form Completion: Parent/Guardian Completing Form: _____

History:

Were there any issues during pregnancy, labor and/or delivery for this child? ❑ Yes ❑ No

If yes, please describe: _____

Does this child have an ongoing health concern? (asthma, diabetes, etc.) ❑ Yes ❑ No

If "yes", please describe: _____

Does this child have any allergies? ❑ Yes ❑ No

If "yes", please list: _____

Has the allergy required emergency treatment? ❑ Yes ❑ No

If "yes", please explain: _____

Are the child's immunizations up to date? ❑ Yes ❑ No

Additional immunizations required: _____ given? _____

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No

If "yes", please describe: _____

Are there any current medical concerns/injuries? ❑ Yes ❑ No

❑ Head ❑ Eyes ❑ Nose _____
❑ Ears _____ ❑ Throat ❑ Neck _____
❑ Chest _____ ❑ Respiratory _____
❑ Cardiovascular _____ ❑ Gastrointestinal _____
❑ Genitourinary _____ ❑ Neurological _____
❑ Musculoskeletal (include any past fractures, etc.) _____

Does this child take any medication regularly at home? ❑ Yes ❑ No

Require medication at school? ❑ Yes ❑ No

If "yes", please describe: _____

Please list any additional concerns or information: _____

_____

Describe child's nutritional pattern and dietary intake: _____

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List any significant medical concerns in family:

❑ Mother _____ ❑Father _____

❑ Siblings ❑ Grandparents _____

❑ Other _____

Who lives with the child in his/her primary household? _____

Does child spend a significant amount of time in another household? ❑ Yes ❑ No

If "yes", please describe: _____

Who has legal custody of this child?

Describe any custody arrangements: _____

Any additional concerns or pertinent information (use back as needed):

Influenza- *not required.*

Newcomb Central School

5535 State Rte 28N, Newcomb, NY 12852 USA

International Student Immunization Record

Student Last Name: _____ First Name: _____

Date of Birth: _____ Date: _____

(mm/dd/yyyy format)

Immunization	Date (m/dd/yy)	Date (m/dd/yy)	Date (m/dd/yy)	Date (m/dd/yy)	Date (m/dd/yy)	Date (m/dd/yy)
DPT or DPaT						
Td						
Tdap						
OPV						
IPV						
MMR (Measles, Mumps & Rubella)						
Measles						
Mumps						
Rubella						
Hepatitis B						
HiB						
Varicella						
Meningococcal ACWY (Menactra, Menveo)						
Meningococcal B (Trumenba, Bexsero)						
Meningococcal C						
Pneumococcal PCV7						
Pneumococcal PCV13						

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Pneumococcal PPSV						
Hepatitis A						
BCG						
HPV						
Influenza						

Please refer to reverse for important clarifying information.

Please SPECIFY the ACTUAL FORMULATION of vaccine for each date entered.

- ***DPT, DPaT, Tdap*** *= Vaccines containing Diphtheria toxoid, Tetanus toxoid, and Pertussis or acellular Pertussis in varying amounts depending on the formulation administered. Td contains only Tetanus and Diphtheria toxoids. Tdap is the formulation* ***required for students born on or after 1/1/1994 and entering 6th through 12th grades in New York State****.* ***Please indicate the date next to the actual formulation that was administered.***
- ***IPV*** *= Inactivated polio virus vaccine.*
- ***OPV*** *= oral polio vaccine*
- ***MMR*** *= Measles, Mumps, Rubella vaccine.* ***If student received separate vaccines against each of these 3 illnesses rather than as a combined vaccine – please indicate this in the appropriate rows.***
- ***Hib*** *= Haemophilus influenza type b conjugate vaccine. Only required for Prekindergarten students.*
- ***Varicella*** *= Chickenpox vaccine*
- ***Meningococcal*** *= Meningococcal vaccines: One dose of Meningococcal conjugate (MenACWY, Menactra or Menveo) required for students entering grades 7& 8. For Grade 12, 2 doses are required, however, if the first dose of meningococcal conjugate vaccine was received at age 16 or older, the second (booster) dose is not required. Meningococcal B or Meningococcal C vaccine is NOT acceptable.*
- ***Pneumococcal*** *= Pneumococcal vaccines: Pneumococcal conjugate (PCV 7 or PCV 13) or Pneumococcal polysaccharide (PPSV). Only required for Prekindergarten students.*
- ***HPV*** *= Human Papilloma Virus vaccine. Not required.*
- ***BCG*** *– not required.*

Influenza*- not required.*

I attest that the information noted above is true and correct to the best of my knowledge.

Authorizing (physician) signature: _____

Printed Name of Authorizing Physician:

_____

Date: _____