WEST ISLIP PUBLIC SCHOOLS

School Health Services

To: Parent/Guardian:

The New York State Education Law requires that every student have a physical exam on this approved NYSED form upon entrance into school at any grade level, and for each student entering Kindergarten, First, Third, Fifth, Seventh, Ninth and Eleventh Grades. The physical exam shall not be more than twelve months prior to the commencement of of the school year in which the examination is required.

It is also recommended that your child visit the family dentist twice annually since school-age children have the highest incidence of dental decay. Please return a Family Dentist Report for your child to the school at your earliest convenience.

FAMILY DENTIST REPORT

DATE:_____

NAME:_____ GRADE:_____

UNDER TREATMENT:_____

TREATMENT COMPLETED:_____

REMARKS:_____

_____

_____
DENTIST'S SIGNATURE

WEST ISLIP PUBLIC SCHOOLS

School Health Services

NYSED requires an annual physical exam for new entrants, students in Grades K, 1, 3, 5, 7, 9 and 11, as well as for sports and working permits.

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** **M** **F** **Grade:** _____ **Date of Exam:** _____

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** Food: _____ Insect: _____ Other: _____

Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):

less than 5th | 5th through 49th | 50th through 84th
85th through 94th | 95th through 98th | 99th and higher

Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
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.

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 Epilepsy Hypertension
Other: _____

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

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above 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. 3/2018 Physical Health Cert Form NYS