



2011-2012 HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____ Gender: M F

Grade _____

IMMUNIZATIONS / HEALTH HISTORY

Immunizations (see back) Sick Cell Screen: Positive Negative Not done Date: _
No immunizations given today PPD: Positive Negative Not done Date: _
Immunizations given since last Health Appraisal: Elevated Lead: Yes No Not done Date: Dental
Referral Yes No Not done
Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____ Referral

Table with 4 columns: Body Mass Index, Weight Status Category (BMI Percentile), Vision - without glasses/contact lenses, Vision - with glasses/contact lenses, Vision - Near Point, Hearing. Includes checkboxes for BMI categories and vision/hearing results.

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
Med _____ Dosage/Time: _____
Med _____ 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: _____
 Restrictions: _____
 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: _____

Provider's Name/Address: _____ Fax: _____

For HIPPA refusal:

Parent Signature: _____ Date _____