HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____ / _____ / _____

School: Elmwood Franklin School Gender: ☐ Male ☐ Female Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached	Sickle Cell Screen:	☐ Positive	☐ Negative	☐ Not done	Date: _____
☐ No immunizations given today	PPD:	☐ Positive	☐ Negative	☐ Not done	Date: _____
☐ Immunizations given since last	Elevated Lead:	☐ Yes	☐ No	☐ Not done	Date: _____
Health Appraisal:	Dental Referral:	☐ 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: _____

				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–49th ☐ 50th–84th	Vision – Near Point	R	L	
☐ 85th–94th ☐ 95th–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 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. 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 QUALIFICATIONS / 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 INFFORMATION, if known

Specify current diseases: ☐ Asthma Diabetes ☐ Type I ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other _____

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

Provider's Name/Address: _____ Fax: _____

Parent's Signature: _____ Date: _____

IN-SCHOOL SCREENINGS

Child's Name: _____ Grade: _____

Parents, Please Check All That Apply

☐ I **DO NOT** want my child to receive vision screening.

☐ I **DO NOT** want my child to receive scoliosis screening.

☐ I **DO NOT** want my child to receive hearing screening.