HEALTH CERTIFICATE / APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

School: **Byron-Bergen Central School District** **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: ______________________ ________

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):	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): ______________________

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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 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: ________

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. 2/08*

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

SCHOOL NAME: **BYRON-BERGEN CENTRAL SCHOOL DISTRICT**

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Student:____ Age:_______________

Grade (check): ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 Date of Birth: ____ /____ /____

Sport:__________________________________ Level (check): ❑ Varsity ❑ JV ❑ Freshman ❑ Jr. High

Date of last health appraisal: _____/_____/_____ Limitations: ❑ Yes ❑No

PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

NOTE: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it will require a review and approval by the school physician before the student can report to practice or tryouts. The answers to the questions on this form will be held in the school health office, and will be kept confidential.

HISTORY SINCE LAST HEALTH APPRAISAL:

If the answer to any of the following questions is "YES", in PART C below, please describe the condition or situation that prompted your answer.

1. Any injuries requiring medical attention? ❑ Yes ❑ No
2. Any illness lasting more than five (5) days? ❑ Yes ❑ No
3. Taking medicine or under physician's care at this time? ❑ Yes ❑ No
4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? ❑ Yes ❑ No
5. Change in wearing glasses or contact lenses? ❑ Yes ❑ No
6. Any surgical operations or fractures? ❑ Yes ❑ No
7. Any treatment in a hospital or emergency room? ❑ Yes ❑ No
8. Developed any allergies? ❑ Yes ❑ No
9. Any chronic disease? ❑ Yes ❑ No

PART C: TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES".

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PART D: PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: ____ DATE: _____/_____/_____

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation: ❑ Approved ❑ Referred to School Physician

Signed: ____________________________________ Date:_____/_____/_____
School Health Office

If referred to the School Physician: ❑ Requalified ❑ Disqualified

Signed: ____________________________________ Date:_____/_____/_____
School Physician

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE