AU SABLE VALLEY CENTRAL SCHOOL — HEALTH CERTIFICATE / APPRAISAL FORM

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

School: _____ **Gender:** ❒ M ❒ F **Grade:** _____ **School Year 2013-2014**

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: ❒ _____

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

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ **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 abnormal findings : _____

MEDICATIONS

Medications (list all): ❒ None

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, play ground, work & school activities OR only as checked:**

___ **Contact**: cheerlead, ski, volleyball, handball, fence, baseball, hockey, softball, football, basketball, soccer and wrestling.
___ **Non-contact**: badminton, bowl, golf, swim, table tennis, tennis, archery, gymnastics, weight train, dance, cross country, track/field, run and walk.

❒ **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: _____

By signing this form, I consent to my child's physical exam and for the release of medical information to the school and/or the health care provider.

Parent/Guardian Signature _____ Date: _____

Provider's Signature: _____ Date: _____

Provider's Name: _____

Address: _____

For Office Use ONLY:

_____
School Physician's Signature Date

HEALTH HISTORY

Child's Name: _____ Age: _____ Birth date: _____

Address: _____ Phone Number: _____

Name of Family Physician or Provider:_____

_____

To be completed by parent/guardian:

Health History during last 12 months:

Does this child have an ongoing health concern? (asthma, diabetes, etc.)	❑ Yes ❑ No
Does this child have any chronic illnesses or conditions?	❑ Yes ❑ No
Does this child have any allergies to medication, food or environmental?	❑ Yes ❑ No
Does the allergy require emergency treatment, such as EPI-PEN?	❑ Yes ❑ No
Does this child have problems with blood pressure, heart, or heart murmur?	❑ Yes ❑ No
Is there a history of any hospitalizations, significant injuries, or surgery?	❑ Yes ❑ No
Any dizziness, fainting, convulsions, seizures, or headaches?	❑ Yes ❑ No
Does this child have any problems with liver, spleen, kidneys, etc.?	❑ Yes ❑ No

Are there any CURRENT medical concerns/injuries? See below ❑ **Yes** ❑ **No**

❑ **Head/concussion** _____ ❑ **Glasses/contacts**_____ ❑ **Eyes** _____ ❑ **Ears**_____
❑ **Hearing**_____ ❑ **Throat** _____ ❑ **Nose /Nose bleeds**_____
❑ **Chest** _____ ❑ **Respiratory** _____ ❑ **Cough**_____ ❑ **Neck**_____
❑ **Cardiovascular** _____ ❑ **Gastrointestinal** _____ ❑ **Heat exhaustion/stroke**_____
❑ **Genitourinary** _____ ❑ **Neurological** _____ ❑ **Skin disease** _____
❑ **Musculoskeletal (include any fractures, etc.)** _____
❑ **Hernia**_____ ❑ **Teeth** _____ ❑ **Dental appliances** _____

Does this child take any medication regularly at home? ❑ **Yes** ❑ **No**
Require medication at school? ❑ **Yes** ❑ **No**
Is this child on any special diet or food restrictions? ❑ **Yes** ❑ **No**

Describe child's nutritional pattern and dietary intake: _____

List any significant medical concerns or sudden death of family members:

❑ **Mother**_____ ❑ **Father** _____ ❑ **Grandparents** _____
❑ **Siblings** _____ ❑ **Other** _____

Please describe any YES responses:

_____

_____

The above information is current and correct to the best of my knowledge.

By signing this form, I consent to my child's physical exam and for the release of medical information to the school and/or the health care provider.

Parent/Guardian Signature: _____ Date: _____

Please be sure to COMPLETE the HEALTH HISTORY and SIGN BOTH SIDES of this form.