

HEALTH CERTIFICATE / APPRAISAL FORM / South Colonie CSD

Name: _____ Date of Birth: _____
 School: _____ 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	<i>Referral</i>
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> 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 Please attach additional medication orders

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: _____

Colonie Central High School **SPORT** _____
Health Office Grade: _____

Parent permission and Health History for _____
This form **MUST BE COMPLETED PRIOR TO TRYOUTS** for **EACH SPORT SEASON!** Please explain all "yes" answers below.

History

DOES YOUR CHILD HAVE:

1. Required medication? _____
2. Allergies to medication? _____
3. Food Allergies? _____
4. Environmental allergies? _____
5. Recent Hospitalizations? _____
6. Disabilities? _____
7. Prosthetic devices? _____

Past Injuries

1. Head injury/Concussion? _____
2. Joint Injury? _____
3. Extremities? _____
4. Back Injury? _____
5. Fractures? _____
6. Sprains? _____
7. Restrictions? _____

Medical Conditions

DOES YOUR CHILD HAVE:

1. Fainting episodes? _____
2. Headaches? _____
3. Asthma? _____
4. Issues with cold/heat? _____
5. Neurologic problems? _____
6. Cardiac problems? _____
7. Any Other Condition? _____

Your Signature indicates that your child has permission to tryout for/play sports at CCHS. It also indicates that we may/will share important medical information with your child's coach. It is **IMPORTANT** to have this information current in the event of an emergency. Please feel free to contact the health office for any questions or concerns. (459-1220 Ext 3500)

Parent/guardian signature _____ Date _____
Please provide **EMERGENCY** phone numbers;

Mom/guardian _____ Dad/guardian _____