

Brasher Falls Central School District

P. O. Box 307 - Brasher Falls, New York 13613

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

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 <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - Near Point	R	L	
	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 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: _____

**BRASHER FALLS CENTRAL SCHOOL DISTRICT
ATHLETIC PERMISSION FORM/HEALTH QUESTIONNAIRE (Cont'd.)
ATHLETIC HEALTH QUESTIONNAIRE**

Name _____ Birthdate _____

Grade _____ Sport _____

Has the athlete ever had:

	Yes	No	Date		Yes	No	Date
1) Epilepsy, convulsions	_____	_____	_____	11) Concussion	_____	_____	_____
2) Fainting	_____	_____	_____	12) Sprain of any joint	_____	_____	_____
3) Heart or blood pressure problem	_____	_____	_____	13) Fractures	_____	_____	_____
4) Family history of sudden death	_____	_____	_____	14) Loss of eye, kidney, testicle	_____	_____	_____
5) Asthma, allergies, hay fever	_____	_____	_____	15) Dental braces or dentures	_____	_____	_____
6) Diabetes	_____	_____	_____	16) Bleeding tendency	_____	_____	_____
7) Hepatitis, Infectious Mono	_____	_____	_____	17) Corrective eyeglasses	_____	_____	_____
8) Kidney disease	_____	_____	_____	18) Hernia	_____	_____	_____
9) Enlarged liver or spleen	_____	_____	_____	19) Recent Surgery	_____	_____	_____
10) Anemia	_____	_____	_____	20) Drug allergies	_____	_____	_____

Please explain any YES answers. Use other side if necessary: _____

Date of last tetanus shot: _____

Current Medications: _____

Date _____ Parent/Guardian Signature _____