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).

McGANN-MERCY HIGH SCHOOL

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: ☐ M ☐ F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

*** PLEASE ATTACH A COPY OF THE IMMUNIZATION RECORD***

_____

Significant Medical/Surgical History: ☐ See attached _____

_____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____

☐ Seasonal ☐ Medication Allergy: _____ _____

PHYSICAL EXAM

DATE OF EXAM: _____ HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

PULSE: _____ URINE: (required for sports) PROTEIN: _____ /GLUCOSE: _____ *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 abnormality (use reverse of form if needed): _____

_____

_____

MEDICATIONS

Current Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

*** Please note separate medication administration form must be completed for medication that is to be taken at school***

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: _____

☐ Restrictions: _____

☐ 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 and Stamp: _____ Date: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

School Physician Signature and Stamp: _____ Date: _____