**WEST ISLIP PUBLIC SCHOOLS**
**HEALTH SERVICES DEPARTMENT**

To: Parent/Guardian:

The New York State Education Law requires that every student have a health examination upon entrance into school at any grade level, and for each student entering Kindergarten, Second, Fourth, Seventh and Tenth Grades.

The periodic health examination performed in the office of the physician of the family's choice is of great value. Health problems can be detected, with correction and treatment started early.

Therefore, you are urged to have your family physician complete the medical examination form. Such examination shall be acceptable if they are administered not more than twelve months prior to the commencement of the school year in which the examination is required. *IF IT IS NOT RETURNED WITHIN 15 DAYS AFTER YOUR CHILD ENTERS SCHOOL, A HEALTH EXAMINATION APPOINTMENT WILL BE SCHEDULED WITH THE SCHOOL PHYSICIAN.*

It is also recommended that your child visit the family dentist twice annually since school-age children have the highest incidence of dental decay. Please return a Family Dentist Report for your child to the school at your earliest convenience.

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FAMILY DENTIST REPORT

DATE: _____

NAME: _____ GRADE:_____

UNDER TREATMENT:_____

TREATMENT COMPLETED: _____

REMARKS:_____
_____

_____
DENTIST'S SIGNATURE

*Recommended / Sample Form*

*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: _____ _____ . _____

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

| | | | *Referral* |
|---|---|---|---|
| Vision - without glasses/contact lenses | R | L | |
| Vision - with glasses/contact lenses | R | L | |
| Vision - Near Point | R | L | |
| 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

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*