

Webster Christian School, Webster, NY 14580

TO BE FILLED IN BY PARENT/GUARDIAN BEFORE PHYSICAL EXAMINATION BY DOCTOR

SCHOOL: Webster Christian School, Webster, NY **GRADE** _____ **SEX** _____

Student Name _____ Birthdate _____ Birthplace _____
Last First

Address _____
Street Town Zip

Mother's Name _____
Home address if different from above Home phone / Work phone

Father's Name _____
Home address if different from above Home phone / Work phone

Physician's Name _____ Physician's Phone _____

Dentist's Name _____ Dentist's Phone _____

If answer is YES to any of the following, write the item number (1 through 17) and give the date of occurrence:

1. Any known allergies to, foods bee/insect stings, latex, medicines, etc.? <ul style="list-style-type: none"> Describe reaction: (local swelling, hives, face swelling) Are emergency meds required? Yes No 	Yes	No
2. Sustained any injury or illness which required medical attention and/or hospitalization or surgery? <ul style="list-style-type: none"> If YES your child may need to be cleared with an MD note to participate in sports/gym. 	Yes	No
3. Is your child under a physician's care now for any existing problem?	Yes	No
4. Absence or loss of function for eye, kidney, testicle, or other organ?	Yes	No
5. Requires any ongoing medication at home or school? List above	Yes	No
6. Has asthma? <ul style="list-style-type: none"> Are emergency meds required? Yes No 	Yes	No
7. Had a convulsion, seizures, concussion, loss of consciousness?	Yes	No
8. Has diabetes?	Yes	No
9. Has recurrent headaches? Explain above (frequency, intensity, any medication)	Yes	No
10. Complained of chest pain or fainting during physical exertion?	Yes	No
11. Has heart disease, murmur, or irregular heart beat?	Yes	No
12. Wears Orthodontic braces? <ul style="list-style-type: none"> If YES is a specialized mouthpiece from an orthodontist required for sports/PE? Yes No 	Yes	No
13. Had any teeth capped or replaced artificially?	Yes	No
14. Wears Glasses? <ul style="list-style-type: none"> For Sports? Yes No If YES, are glasses impact resistant?----Yes No Contact lenses? Yes No If YES, How long? 	Yes	No
15. Wears Hearing Aid Devices? Type	Yes	No
16. Is there any medical condition or restriction which may be made worse by playing sports/PE?	Yes	No
17. Required by MD to wear brace/support device to play sports/PE?	Yes	No

I certify that the above information is true and accurate and understand that it will be relied upon by the Webster Christian School. If medication is prescribed (only valid for current school year) on the health appraisal on reverse side, I authorize the school nurse to administer the prescribed medication as directed by health care provider. I authorize the school nurse to contact the health care provider regarding information on this health appraisal form on reverse side for one calendar year from the date I signed below.

Parent/Legal Guardian Signature _____ **Date** _____

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached Sickle Cell Screen: Positive Negative Not done Date: _____
 No immunizations given today PPD: Positive Negative Not done Date: _____
 Immunizations given since last Health Appraisal: Elevated Lead: Yes No Not done Date: _____
Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

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

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Referral

Table with 4 columns: Body Mass Index, Weight Status Category (BMI Percentile), Vision - without glasses/contact lenses, Vision - with glasses/contact lenses, Vision - Near Point, Hearing. Includes checkboxes for BMI categories and vision/hearing test results.

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: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____