



**GREENVILLE**  
CENTRAL SCHOOL DISTRICT

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HS/MS Nurse 518-966-5070 ext. 420  
Fax: 518-966-5338

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**HEALTH CERTIFICATE / APPRAISAL FORM**  
For All New Entrants and Students Entering Grades K, 2, 4, 7, and 10  
*Completed by Physician*

**Name:** \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_  
**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 \_\_\_\_\_

**Specify current diseases:**  Asthma\*\*  Diabetes\*\*:  
 Type 1  Type 2  
 Hyperlipidemia  Hypertension  
 Other: \_\_\_\_\_

\*\*\*\* List All Medications/Treatments on page 2 of Health Appraisal Form\*\*\*\*

**Allergies:**  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

**PHYSICAL EXAM**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

**REQUIRED:**

**REQUIRED:**

*Referral*

Body Mass Index: _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Vision - Near Point	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> 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): \_\_\_\_\_

*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. 11/2/09*

**MEDICATIONS**

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

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

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**

**Physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

\_\_\_ Limited contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

\_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, 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: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp Below)

Physician's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**REQUIRED IMMUNIZATIONS FORM**

**Public Health Law 2164 requires that the following immunizations must be received prior to the child being allowed to enter school:**

- 3 Polio (OPV or IPV)**
- 3 DPT, DTaP, or DT (diphtheria-pertussis-tetanus vaccine). FULL DOSES ONLY.**
- 2 MMR or**
  - 2 Measles vaccine**
  - 1 Mumps vaccine**
  - 1 Rubella vaccine**
- 3 Hepatitis B vaccines** **1**
- Varicella vaccine** for all children born on or after 01/01/1998 and all children born on or after 01/01/1994, in 6<sup>th</sup>-10<sup>th</sup> grades **or physician documentation regarding history of disease.**
- 1 Tdap** for all students entering 6<sup>th</sup> through 8<sup>th</sup> grade and who are 11 years of age or older.

**The district needs proof of compliance with this law at the time you register your child into the school district. Adequate proof is written certificate or record from the physician's office, a transcript from the previous school.**

If the immunizations have not been completed by the date your child is to enter school, **we must exclude the child from school** until the immunizations have been completed or until proof of satisfactory progress toward this completion is shown. Please be advised that the law requires us to exclude children for up to two weeks if the process is not taking place and that, after two weeks of exclusion, we are required to notify Child Protective Services which is a division of the Greene County Department of Social Services.

**STUDENT'S NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

<b>IMMUNIZATIONS</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>
OPV (3)	__/__/__	__/__/__	__/__/__		
IPV (4)	__/__/__	__/__/__	__/__/__	__/__/__	
DPT,DTaP	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
DT	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Measles	__/__/__	__/__/__			
Mumps	__/__/__				
Rubella	__/__/__				
MMR	__/__/__	__/__/__			
Hepatitis B	__/__/__	__/__/__	__/__/__		
Varicella	__/__/__	History of Diseases on	__/__/__		
HIB	__/__/__	__/__/__	__/__/__		
Tdap (Age 11)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

**Physician's Signature:** \_\_\_\_\_

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