

**City School District of Peekskill**  
**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:(within one year) ☐ 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	Referral
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): \_\_\_\_\_

**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: \_\_\_\_\_