Elementary: (518) 895-2580 / Fax (518) 895-2957
MS/HS (518) 895-2355 / Fax (518) 895-9971

Website – www.duanesurg.org

## Duanesburg Central School

# 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: ____________

Elementary: (518) 895-2580 / Fax (518) 895-2957
MS/HS (518) 895-2355 / Fax (518) 895-9971
Website – www.duanesurg.org

**Duanesburg Central School**

**Duanesburg Elementary School**
**165 Chadwick Road**
**Delanson, NY 12053**

**Duanesburg Jr/Sr High School**
**163 School Drive**
**Delanson, NY 12053**

**Dear Parent/Guardian:**

**Your health care provider will require the release of information form below to share protected medical information with the school district. Please sign and give the form to your healthcare provider or school nurse to avoid delays.**

## *AUTHORIZATION for USE or DISCLOSURE of PROTECTED HEALTH INFORMATION*

**I, ________________________________________________, authorize my child's healthcare provider(s) listed below to release my child's, ___________________________________, medical records to the school district's medical officer, physical, occupational, or speech therapist, and/or school nurse:**

**Name** ____________________________________ **phone** _________________ **fax** ________________

**Name** ____________________________________ **phone** _________________ **fax** ________________

**Name** ____________________________________ **phone** _________________ **fax** ________________

**Name** ____________________________________ **phone** _________________ **fax** ________________

**The healthcare provider may disclose the following protected health information: (check all that apply):**

- ☐ **Immunizations**
- ☐ **Health Appraisals**
- ☐ **Past/Current Medical Condition and its impact on attendance, school programming and/or PT, OT, ST needs**
- ☐ **Past/Current Medications and their impact on attendance, school programming and/or PT, OT, ST needs**
- ☐ **Other** ____________________________________________________________________________

**Please select one:**

- ☐ **This authorization is valid for the entire academic school year September ________ to June _________.**
- ☐ **This authorization shall expire on _____/_____/_____ (day / month / year** *ie. – 02 May 2011* **)**

**I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the school district nurse or therapist involved.**

**I understand that the revocation of this authorization is not effective if the Healthcare Provider or school district has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.**

**I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.**

**I understand that my child's treatment is not dependent on my agreement to release or withhold information.**

______________ ________________________________________ ______________________________
Date Signature of Parent/Guardian Relationship to Patient

**Parent/Guardian: SIGNING this AUTHORIZATION is *OPTIONAL***

Elementary: (518) 895-2580 / Fax (518) 895-2957
MS/HS (518) 895-2355 / Fax (518) 895-9971
Website – www.duanesurg.org

**Duanesburg Central School**

## ***Health History for in-coming "K", and all New Students***

**Student Name __________________________ Birthdate ______________ Sex ____ Gr.______**

***Please indicate if any of the following illness/conditions have affected your child:***

***Birth history***: Full Term ___ Premature ___ Condition at birth____________

***Acute Illness***: Whooping Cough_____ Rheumatic Fever_____ Scarlet Fever_____ Tuberculosis _____

Mononucleosis____ Pneumonia____ Chicken Pox____ Fifths Disease____ Hepatitis_____ Measles _____

Other_________________________ Strep Throat {last occurrence}________ Frequency_______________

***Chronic Illness***: **Asthma**_____ Triggers ______________________________ Controlled with_______________ ,

**Allergies**_____ To what? ________________________ Controlled with___________________

**Diabetes**_____ Controlled with________________________ Self administered? _____________

**Heart defect/condition**_________________ Treatment______________________________ Seizures [date of last one and type]__________________Controlled with__________________

**Urinary/Bowel problems** _________________________ **Toileting issues**____________________

**Neurologic Condition**_____________________ **Autism** ___________**Cerebral Palsy**____________

***Has your child been diagnosed with***: ADD or ADHD? ___________ Date _________________
Doctor_______________Medication________________________ Dose______ Frequency______________ Behavior or emotional Problems _______________________ Learning Disabilities ________ Speech Issues_____________________

**Orthopedic problem**_____________________________
Uses: braces____ Crutches ____ Cane _____ Walker ____ Wheelchair _____

**Ear Infection** ~ Frequency_____________ Tubes/date_____ Hearing Loss ______Hearing Aids ____ L / R

**Vision:** Normal_____ Wears Glasses_______ For____________ When____________________

**Occupational Therapy**:___ for_______________ Physical Therapy: ___ for__________________

***Has your child ever had surgery***?_______________________________ Date______________

**Medications student is currently taking**______________________________ for_________________
Is there a need to take the medication in school? Yes____ No ____

**Dental problems/appliances** :__________________________________________________

Last school attended if any ____________________________________________________

**Please state below anything else the school nurse should be made aware of**:

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Pediatrician's name** ____________________________________ **Phone** _______________________

**Dentist** ________________________________________________ **Phone** _______________________

**Parent/Guardian signature**______________________________________ **Date** _________________