LOUDONVILLE CHRISTIAN SCHOOL

374 Loudon Road, Loudonville, NY 12211 | www.lcs.org | 518-434-6051
Fax Number is 518-935-2258

HEALTH FORM

Dear Parents:

New York State Education Law requires that each student receive a physical exam when **entering a school district for the first time** and again in **grades K, 2, 4, 7, 10.** This law also requests a comprehensive dental exam. While the physical examination can be administered by the school physician, and we can offer you names of dentists in the community; we urge you to use your family physician/dentist for this purpose during your child's summer vacation. In this manner, a pattern of consistent, optimum health care can be established.

If your child has recently seen your family physician/dentist and will be a beginning **Kindergartner, 2nd, 4th, 7th, or 10th grader** in September, please ask the doctor to complete the reverse side of this form as well as the dental form. Although the forms must be returned by the end of September, an examination administered not more than twelve months prior to commencement of the school year in which the examination is required, will be accepted. For those beginning **Kindergartners, 2nd, 4th, 7th and 10th** graders who have not received examinations from a private physician by September, a visit to our school physician will be scheduled in the fall.

Again, please return this form to your school nurse by the **end of September**. You are reminded of the following:

1. To notify us if it is necessary for your child to be absent due to illness Call the school the first day of absence.
2. To keep us informed during the school year on items below (changes)
3. When the annual school health appraisals are made, you will be notified if any abnormalities are found.

Please feel free to call us or send a note if we may be of assistance to you at any time.

To be completed by Parent:

Name of Pupil________________________________Grade__________Teacher______________________

Mailing Address____Telephone_________________________

Parent/Guardian (home)_________________(work) _______________
Parent/Guardian (home)_________________(work) _______________

Names of person, other than parents, to be called in case of emergency if neither parent can be reached

1. Name___________________Address______________________Hm. Tel._________Wk. Tel.____________

2. Name___________________Address______________________Hm. Tel._________Wk. Tel______________

Family Physician___________________________Address________________________Phone #____________
Family Dentist_____________________________Address________________________Phone #____________
Medical Problems____
Date__________________ Parent's Signature_______________________________

1/15 DJD/appDS

(OVER)

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:____________________ **SPORTS TO BE PLAYED:**____________

School: ____________ **Gender:** ❑ M ❑ F **Grade**______ **Date of Birth:**__________

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:______. ____					Referral
Weight Status Category (BMI Percentile):		Vision - without glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th		Vision - with glasses/contact lenses	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher		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 list on additional form **ICD9 Code**______

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. 1/15DJD