



# 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, 1, 3, 5, 7 and 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, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup> or 9<sup>th</sup> 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, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup> or 9<sup>th</sup> 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 _____	
5/18 LCS		

(OVER)

NYSED requires an annual physical exam for new entrants, students in Grades K, 1, 3, 5, 7, 9 and 11, 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: _____ Weight Status Category (BMI Percentile): <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> <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	Vision - without glasses/contact lenses	R	L	Referral
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	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 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. 5/18 LCS