MILL NECK MANOR SCHOOL
40 FROST MILL ROAD
MILL NECK, NY 11765
(516) 922 – 4100
HEALTH OFFICE: (516) 922 – 4100, EXT 233 FAX: (516) 922 – 0203

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: ☐ DEC ☐ ECC 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

Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db at 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: _____

OPTIONAL INFORMATION, If known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other:

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ Free from contagion & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
___ Limited contact: cheerleading, gymnastics, volleyball, cross-country, baseball, floor hockey, softball.
___ Non-contact: badminton, bowling, golf, table tennis, tennis, archery, weight - train, dance, track, run, walk, jump rope.

☐ 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: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

IMMUNIZATION RECORD

Name: _____ D.O.B. _____

Please Circle Type of Vaccine

	Date		Date		Date		Date
DTP, DT, HIB/DTP	_____	TOPV,IPV	_____	MMR#1	_____	HIB	_____
DTP, DT, HIB/DTP	_____	TOPV,IPV	_____	MMR#2	_____	HIB	_____
DTP, DT, HIB/DTP	_____	TOPV,IPV	_____	MEASLES#1	_____	HIB	_____
DTP, DtaP, DT, HIB/DTP	___	TOPV,IPV	_____	MEASLES#2	_____	HIB	_____
DTP, DtaP, DT, HIB/DTP	___	TOPV,IPV	_____	MUMPS	_____		
				RUBELLA	_____		

	Date		Date
HEPATITS B	_____	*TB Test (PPD)	_____
HEPATITS B	_____	(Results)	_____ mm
HEPATITS B	_____		
COMVAX	_____	VARIVAX	_____

OTHER

Vaccine	Dates
_____	_____
_____	_____
_____	_____
_____	_____