102 R1/2008

WESTBURY PUBLIC SCHOOLS
WESTBURY, NEW YORK 11590

SCHOOL HEALTH FORM – PHYSICIAN'S CERTIFICATE

THIS FORM IS TO BE COMPLETED AND SIGNED BY A MEDICAL DOCTOR

Student's Name: _____ DOB: _____

Height: _____ Weight: _____ Referral

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 – withouth 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	

Blood Pressure: _____ Nervous System: _____

Nutrition: _____ Speech: _____

Teeth and Gums: _____ Tonsils and Throat:_____

Glands – Cervical: _____ Thyroid: _____

Heart and Lungs: _____ Skin: _____

Orthopedics: Spinal Deviation: _____ Scoliosis: _____ Feet: _____

Genitalia (male): _____ Urianalysis (if done): _____

Does this child have any condition requiring on-going medical care? ____ YES ____ NO
If YES, please specify: _____
Does this child have a defect or disability? ____ YES ____ NO
If YES, please specify: _____
Are there any issues relating to the growth, development or nutrition of this child with which his/her teachers should be acquainted? ____ YES ____ NO
If YES, please specify: _____
Should any restrictions be placed on this child's participation in physical activities? ____ YES ____ NO
If YES, please specify: _____
Does this child take any medication (other than vitamins) on a regular basis? ____ YES ____ NO
If YES, please specify: _____
Are there any other medical issues of which the school should be aware regarding this child? ____ YES ____ NO
If YES, please specify: _____

Immunization:	Date(s) of Administration:		
1. Polio/OPV	1_____ 2_____ 3_____	9. M/M/R	1_____ 2 _____
	Booster _____ _____	Measles	1_____ 2_____
2. DPT/DTAP	1_____ 2_____ 3_____	Mumps	1_____
	Booster _____ _____	Rubella	1_____
3. TD	1_____ 2_____ 3_____	10. Mantoux	1_____
4. TDAP	1_____	(within 1 year)	(required for new entrants including the results)
5. HIB	1_____ 2_____ 3_____		
6. HEP.B	1_____ 2_____ 3_____	11. HPV (Gardesil)	1_____
7. PCV (Prevnar)	1_____ 2_____ 3_____ 4_____	12. HEP. A	1_____ 2_____
8. Menactra	1_____	13. Varicella	1_____ 2_____

Signed: _____ Title: _____
Address: _____ License #: _____
Telephone #: _____ Date of Examination: _____