Health Exam / Immunization Record

SOLOMON SCHECHTER SCHOOL OF WESTCHESTER

To be completed and signed by the health care provider

Required for new students and students in grades K, 1, 3, 5, 7, 8, 9, 11, or 12; interscholastic sport; and working papers

Name: ______________________________ Date of Birth: ______________________

Address: ____________________________ Gender: __________ Grade: __________

IMMUNIZATIONS / HEALTH HISTORY

❒ Updated Immunization Record Attached
PPD:❒ Not required ❒ Positive ❒Negative Date: __________
Significant Medical/Surgical History: ______________________________

CURRENT MEDICAL PROBLEMS

❒ Asthma ❒ Diabetes ❒ Seizures ❒ Hypertension ❒ Hyperlipidemia ❒ Cardiac ❒ Other __________
❒ Allergies: ❒ LIFE THREATENING ❒ Food __________❒ Insect __________❒ Seasonal __________
❒ Other ____________________

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 print	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______________________________

MEDICATIONS TAKEN

Medications taken: list all. ❒ None

Name: ______________________________ Dosage/Time: __________

Name: ______________________________ Dosage/Time: __________

Name: ______________________________ Dosage/Time: __________

SPORTS CLEARANCE/ PHYSICAL EDUCATION / PLAYGROUND / CSE CONSIDERATION

❒ Free from contagions and physically qualified for all competitive and non-competitive sports, physical education, playground and school activities OR
❒ Restrictions as follow

- ❒ Limited Contact/Impact Only (basketball, baseball, softball, volleyball, cheerleading)
- ❒ Strenuous Endurance/Non-contact Only (cross-contact, track & field, swim, tennis, skiing)
- ❒ Non-Strenuous/Non-contact Only (bowling, golf)
- ❒ Other______________________________

❒ Specify medical accommodations needed for school ____________________ ❒ None

❒ Known or suspected disability ____________________ ❒ Please monitor

❒ Protective equipment required ❒ Athletic cup ❒ Sport goggles/impact resistant eyewear ❒ Other __________
Provider's Signature: ____________________ Phone: __________ (Stamp below)

Provider's Name/Address: ____________________ Fax: __________

Parents/guardians may attach a digital copy of this to the student's SuperForm or email it to the school nurse.
Lower School: LSNurse@schechterwestchester.org Upper School: USNurse@schechterwestchester.org