# HEALTH APPRAISAL

REVISED 2/06

Student Name _____ Date of Birth _____

Address _____ Phone _____

## IMMUNIZATIONS/SCREENING

☐ Immunizations given since last Health Appraisal: ☐ None given today ☐ Immunization record attached

| | 1st | 2nd | 3rd | 4th | 5th |
|---|---|---|---|---|---|
| DTaP | * | * | * | | |
| dT/Tdap | * | * | * | | |
| OPV/IPV/eIPV | * | * | * | | |
| MMR | * | * | | | |
| Hep B | * | * | * | | |
| Varicella | * | ☐ Disease | | | |
| HIB | | | | | |
| Other | | | | | |
| Other | | | | | |

PROVIDE MO/D/YR FOR ALL; * Required for entry to school in NYS

| SICKLE CELL SCREEN | | Date |
|---|---|---|
| Positive | Negative | |
| PPD | | Date |
| Positive | Negative | |
| BLOOD LEAD TEST | | Date |
| | mcg/dL | |

| | | |
|---|---|---|
| Vision—without glasses/contact lenses | R | L |
| Vision—with glasses/contact lenses | R | L |
| Vision---Near Point | R | L |
| Hearing | R | L |

**Significant Medical/Surgical History** ☐see attached _____

**Allergies**: ☐None ☐Food ☐Insect ☐Seasonal ☐Medication ☐LIFE THREATENING _____

## PHYSICAL EXAM

☐ Check here if entire exam normal Height _____ Weight _____ B.P. _____

| | Normal | Abnormal | Comments |
|---|---|---|---|
| General Appearance | | | |
| Nutrition/Body Mass Index | | BMI = / % | |
| Skin | | | |
| Head | | | |
| Eyes | | | |
| Ears | | | |
| Nose, Throat, Teeth | | | |
| Lymph Nodes/Thyroid | | | |
| Lungs | | | |
| Heart | | | |
| Abdomen | | | |
| Genitalia | | | Tanner - I. II. III. IV. V. |
| Musculoskeletal | | | Scoliosis / Negative / Positive |
| Neurological | | | |

**Medication** (list all): ☐ None

Name _____ Dosage/Time _____

Name _____ Dosage/Time _____

If AM dose is missed at home _____

I assess this student ☐ to be self directed and ☐ may self-carry medication (School nurse to also assess self-direction in school)

Please send in additional medication in the event that emergency sheltering is necessary at school.

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

☐ Physically qualified for sports or full playground OR only as checked below:

____ Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water polo

____ Limited contact: cheerleading, field, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softball

____ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weights, crew, dance, track, running, walking, jump rope

____ Knowledge based experience only

☐ Physically qualified for employment OR specify accommodation _____

☐ Known or suspected disability _____ ☐ Please monitor

☐ Restrictions _____ ☐ Please monitor

☐ Protective equipment required ☐ Athletic cup ☐ Glasses/ sport eyewear ☐ Other _____

NYS Education Department requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 & 10, sports, working permits, and, triennially, for the Committee on Special Education (CSE). This exam complies with NYSED requirements above and is valid for one year through the last day of the month dated below with the exception of any illness or injury lasting more than five days that will negate this exam.

**PROVIDER'S SIGNATURE** _____ Date _____

**PROVIDER'S NAME** _____ Phone _____ FAX _____

I give permission for medication to be administered to my child as ordered by my health care provider. I give permission for photographs to be taken of my child to be used on the medication bottle and log.

**PARENT/GUARDIAN SIGNATURE** _____ Date _____