# HEALTH APPRAISAL FORM

**Name:** _____ **Date of Birth:** _____

**Address:** _____ **Phone:** _____

## IMMUNIZATIONS

☐ Immunization record attached ☐ No immunizations given this visit

| | 1st | 2nd | 3rd | 4th | 5th |
|---|---|---|---|---|---|
| **DTaP** | | | | | |
| **IPV** | | | | | |
| **HIB** | | | | | |
| **Pneumococcal** | | | | | |
| **Hep B** | | | | | |
| **MMR** | | | | | |
| **Varivax** | | | | | |
| **Other** | | | | | |

| Sickle Cell Screen | |
|---|---|
| Positive | Negative |

| Lead Screen | |
|---|---|
| Positive | Negative |

| | | |
|---|---|---|
| Vision - Without Glasses/Contact Lenses | R | L |
| Vision - With Glasses/Contact Lenses | R | L |
| Vision - Near Point | R | L |
| Hearing | R | L |

**1. Significant Medical/Surgical History:**

**2. Allergies**

**3. Medication taken regularly:**

## PHYSICAL EXAM

Height: _____ Weight: _____ B.P.: _____ Resting Pulse: _____

☐ Check here if entire exam normal

| | Normal | Abnormal | Comments |
|---|---|---|---|
| General appearance | | | |
| Nutrition | | | 1-5: <1=Anorexic, 3=WNL, 5=Obese |
| Skin | | | |
| Head | | | |
| Eyes | | | |
| Ears | | | |
| Nose, Throat & Teeth | | | |
| Lymph Nodes | | | |
| Lungs | | | |
| Heart | | | |
| Abdomen | | | |
| Genitalia | | | Tanner - I. II. III. IV. V. |
| Musculoskeletal | | | |
| Scoliosis | Negative | Positive | |
| Neurological | | | |

**4. Medication to be given at school:**

Name:

Dosage/Time:

If AM dose is missed at home:

I assess this student to be self directed and may self-carry medication ☐ Yes ☐ No

## SPORTS QUALIFICATION

☐ **Physically qualified for sports as indicated below (check HIGHEST LEVEL for participation):**

____Contact/Collision: basketball, boxing, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling.

____Non-contact/strenuous: cheerleading, field, gymnastics, skiing, volleyball, track & field, cross-country, handball.

____Non-strenuous: badminton, bowling, golf, swimming, table tennis, tennis, archery, riflery.

☐ **Physically qualified for employment**

☐ **Known or suspected disablilty:** _____

Provider's Name: _____ Phone: _____

Provider's Signature: _____ Date: _____

1/02