NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

Grade: ________

HEALTH APPRAISAL FORM

School: ____________________

Name: ______________________________ **Gender:** ❑ M ❑ F **Date of Birth:** ____________________

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: __________
Lead Screen: ❒ Positive ❒Negative ❒ Not done Date: __________
Dental Referral ❒ Yes ❒ No ❒ Not done Date: __________

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Significant Medical/Surgical History: ❒ See attached ______________________________

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Specify current disease: ❒ Asthma Diabetes: ❒ Type I ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension ❒ Sleep Apnea
❒ Other: ______________________________

Allergies: ❒ **LIFE THREATENING** ❒ Food: __________ ❒ Insect: __________ ❒ Other: __________
❒ Seasonal ❒ Medication: ____________________ __________

PHYSICAL EXAM

Height: ____________ Weight: ____________ Blood Pressure: ____________ Date of Exam: ____________

Body Mass Index: ____ ____ . ____	Vision - without glasses/contact lenses	R	L	*Referral*
Weight Status Category:	Vision - with glasses/contact lenses	R	L	
❑ < 5th ❑ 5th to 49th ❑ 50th to 84th	Vision - Near Point	R	L	
❑ 85th to 94th ❑ 95th to 98th ❑ 99th & higher	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 (use reverse of form if needed): ______________________________

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MEDICATIONS

Medications (list all): ❒ None ❒ Additional medications listed on reverse of form

Name: ______________________________ Dosage/Time: ______________________________

Name: ______________________________ Dosage/Time: ______________________________

If AM dose is missed at home: ______________________________

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: ______________________________ ❒ None

❒ **Known or suspected disability:** ______________________________ ❒ Please monitor

❒ **Restrictions:** ______________________________ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Glasses/Eyewear ❒ Other: ____________________

(Stamp below)

Provider's Signature: ______________________________ Phone: ____________________

Provider's Name/Address: ______________________________ Fax: ____________________

Parent Signature: ______________________________ Date: ____________________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 9/21/07