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

HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

IMMUNIZATIONS/HEALTH HISTORY

- ❑ Immunization record attached
- ❑ No immunizations given today
- ❑ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ _____
PPD: ❑ Positive ❑ Negative ❑ _____
Elevated based: ❑ Yes ❑ No ❑ _____
Central Referral: ❑ Yes ❑ No ❑ _____

Significant Medical/Surgical History: ❑ See attached: _____

Allergies: ❑ LIFE THREATENING ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of : _____

Vision - without glasses/contact lenses		R	L	
Vision - with glasses/contact lenses		R	L	
Vision - Near Point		R	L	
Hearing ❑ Pass 20 db both ears on		R	L	

❑ **EXAM ENTIRELY NORMAL** Tanner I. II. III. IV. V. Scoliosis: ❑ Negative: ❑ Positive: ❑

Specify any abnormality (use reverse of form if needed:) _____

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.

❑ Free from contagious & physically qualified for all physical education, sports, playground, work and 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 suspected disability: _____ ❑ Please monitor

❑ Restrictions: _____ ❑ Please monitor

❑ Protective equipment required: ❑ Athletic Cup ❑ Sport goggles/Impact resistant 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 an illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.