

### HEALTH APPRAISAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

#### IMMUNIZATIONS / HEALTH HISTORY

- |   |   |                                   |             |
|---|---|-----------------------------------|-------------|
| <input type="checkbox"/> Immunization record attached                     | Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | <input type="checkbox"/> Not done | Date: _____ |
| <input type="checkbox"/> No immunizations given today                     | PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative                | <input type="checkbox"/> Not done | Date: _____ |
| <input type="checkbox"/> Immunizations given since last Health Appraisal: | Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No                 | <input type="checkbox"/> Not done | Date: _____ |
|   | Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No               | <input type="checkbox"/> Not done | Date: _____ |

Significant Medical/Surgical History:  See attached \_\_\_\_\_

- Specify current diseases:  Asthma Diabetes:  Type 1  Type 2  Hyperlipidemia  Hypertension  
 Other: \_\_\_\_\_
- Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

#### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_ Referral

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5th <input type="checkbox"/> 5th through 49th <input type="checkbox"/> 50th through 84th	Vision - Near Point	R	L	
<input type="checkbox"/> 85th through 94th <input type="checkbox"/> 95th through 98th <input type="checkbox"/> 99th and higher	Hearing <input type="checkbox"/> 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): \_\_\_\_\_

#### MEDICATION

- 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  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 any illness or injury lasting more than fivedays that will require review by private healthcare provider and the school medical director. Rev. 10/3/07*

Students in Pre-k, K, 1,2,3 and any student in Grade 4-6 not playing basketball- please complete History on back.  
 Students in Grade 4 -6 playing basketball- Please complete yellow Athletic Health History