# Solvay Union Free School District – Health Appraisal Form

The New York State Education Department requires an annual physical for new entrants, students in grades K, 2, 4, 7 and 10, Interscholastic sports (yearly), working permits and triennially for the Committee on Special Education (CSE)

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

**School:** _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

## 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: _____
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: _____
Dental Referral ❒ Yes ❒ No ❒ 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:** _____/_____ **U/A:** **Albumin** _____ **Glucose** _____

**Resting HR:** _____**Extrasystole?** _____**Murmur?** _____**After exercise/positional change:** _____ **Extrasystole?**____ **Murmur?**_____

| | | | | *Referral* |
|---|---|---|---|---|
| Body Mass Index: _____ _____ . _____ | Vision - without glasses/contact lenses | R | L | |
| Weight Status Category (BMI Percentile): | Vision - with glasses/contact lenses | R | L | |
| ❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th | Vision - Near Point | R | L | |
| ❑ 85th through 94th ❑ 95th through 98th ❑ 99th and 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): _____

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

❒ **Free from contagions & physically qualified for all physical education, interscholastic 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)

## MEDICATIONS

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

Name: _____ Dosage _____ Route _____ Time: _____ Give at school? _____

Name: _____ Dosage _____ Route _____ Time: _____ Give at school? _____

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.)

Provider's Signature: _____ Date of Exam: _____

Provider's Name/Address: _____ Phone: _____ Fax: _____

Parent Signature: _____ Date: _____ Rev. 7/15/08