

COLD SPRING HARBOR CENTRAL SCHOOL DISTRICT

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).

HEALTH APPRAISAL FORM

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 ☐ Hypertipidemia ☐ Hypertension
☐ Other: _____
Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

PHYSICAL EXAM

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

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

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
☐ 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 five days that will require review by private healthcare provider and the school medical director. Rev. 10/3/07

Name _____ Sex M ___ F ___ Grade _____ Sport _____

SPORTS CANDIDATE HEALTH HISTORY

1. Have you ever had any fractures, dislocations, severe sprains or serious injuries?.....Yes ___ No ___
2. Have you ever been hospitalized?.....Yes ___ No ___
3. Have you ever had surgery?.....Yes ___ No ___
4. Do you have any allergies?.....Yes ___ No ___
5. Do you take any medications now?.....Yes ___ No ___
6. Have you ever been refused permission to participate in athletics?.....Yes ___ No ___
7. Have you ever experienced any type of head injury or concussion?.....Yes ___ No ___
8. Do you wear glasses? _____ Contact Lenses? _____

Please explain any "yes" answers to the questions above:

This certifies that the above mentioned student is physically qualified to participate in the following categories of competition this school year.

<u>Contact</u>	<u>Limited Contact</u>	<u>Non-Contact</u>	<u>Moderately Strenuous</u>	<u>Non-Strenuous</u>
Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Floor Hockey	Baseball	Aerobic Exercise	Bowling	Archery
Football	Basketball	Badminton	Golf	Board Games
Ice Hockey	Fencing	Crew	Recreational Games	Computer Games
Lacrosse (Boys)	Field Hockey (Girls)	Cross Country	Table Tennis	
Wrestling	Gymnastics	Jogging		
	Lacrosse (Girls)	Paddleball		
	Soccer	Relays		
	Softball	Swimming		
	Team Football	Tennis		
	Touch Football	Track & Field		
	Ultimate Frisbee	Weight Training		
	Cheerleading	Volleyball		

Reason for disqualification _____

Date _____ PHYSICIAN _____

This certificate is void if the pupil is absent from school five (5) or more days because of illness or because of a significant injury. He/She must be re-certified before participation again.