*NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and Annual & Program Reviews and Reevaluations for the Committee on Special Education (CSE)*

*****PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

City School District of New Rochelle – Health Services Department

# HEALTH APPRAISAL FORM

Date of Exam: ___/___/___

**Name:** _____ **Date of Birth:** ___/___/___ Gender: ❑ M ❑ F

School: _____ Grade: ____

## IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal: (include dates)

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: _____
PPD: Please complete screening on reverse side of form
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: _____ Date of Exam: _____

Body Mass Index: _____ _____ . _____ (Required by NYS)

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

| | | | *Referral* |
|---|---|---|---|
| Vision - without glasses/contact lenses | R | L | |
| Vision - with glasses/contact lenses | R | L | |
| Vision - Near Point | R | L | |
| Hearing ❑ Pass 20 db sc both ears or: | R | L | |

❑ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❑ Negative ❑ Positive: _____
For Girls: Age of onset of menses: _____ LMP: _____
Specify any abnormality (use separate paper if needed): _____

## 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: _____

SPORTS CLEARANCE : By signing and submitting this form, the parent and physician attest that they have fully disclosed all of this student's health history, conditions, medications and relevant family history (e.g., early cardiac death.) Parent and physician assume liability for non-disclosures of such information. The School District Physician has final authority to medically clear students for interscholastic sports participation. Parental signature authorizes School Health personnel to communicate with your child's physician regarding medical clearance for sports.

**Provider's Signature:** _____ **Phone:** _____

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

*****Parent Signature:** _____ **Date:** _____

*H-1 HEALTH APPRAISAL FORM (Revised 2/08)*
*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.*

*****PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

TUBERCULOSIS TESTING / SCREENING – EITHER A OR B MUST BE COMPLETED BY THE PHYSICIAN

**A.** PPD (Mantoux):

**1.** Date placed _____ Date read _____ Result in mm _____

**2.** If PPD is Positive: CXR: Date of exam: ____/____/____ Result: _____

Treatment: _____

_____

**B.** Tuberculin screening not indicated _____ (MD must initial)

PRESCRIPTION MEDICATIONS

Medications (list all): ❒ None

Medication: _____ Dosage/Time: _____

Medication: _____ Dosage/Time: _____

Medication: _____ 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. ***Students are not permitted to carry or self-administer USDEA controlled drugs.** 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.

PERMISSION TO RECEIVE PRESCRIPTION AND OVER THE COUNTER (OTC MEDICATION)

Health Care Provider and Parent signatures required

Parents must provide all medications.

| | | | |
|---|---|---|---|
| ❒ Tylenol (pain, fever) | Dose _____ | Freq._____ | Route_____ |
| ❒ Ibuprofen (Advil, Motrin) (pain, fever) | Dose _____ | Freq._____ | Route_____ |
| ❒ Benadryl (Allergic reaction/Allergy) | Dose _____ | Freq._____ | Route_____ |
| ❒ Antacid (Maalox, Tums) (abdominal discomfort) | Dose _____ | Freq._____ | Route_____ |
| ❒ Cough Drops/Throat Lozenges (sore throat) | Dose _____ | Freq._____ | Route_____ |
| ❒ Antibiotic Ointment (skin lesions) | Dose _____ | Freq._____ | Route_____ |

## SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE TO DISPENSE PRESCRIPTION AND OTC MEDICATION

(Stamp below)

**Provider's Signature:** _____ **Phone:** _____

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

*****Parent Signature:** _____ **Date:** _____

Parental signature authorizes School Health personnel to communicate with your child's physician regarding prescription and OTC medication.