Newburgh Enlarged City 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 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: ______________________

Allergies: ❒ **LIFE THREATENING** ❒ Food: ________ ❒ Insect: ________ ❒ Other: ________
❒ Seasonal ❒ Medication: ______________________ ________

PHYSICAL EXAM

Height: ________ Weight: ________ Blood Pressure: ________ Pulse________ Urine________ Date of Exam: ________

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

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

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____

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

Sports Participants complete reverse side

ATHLETIC PREPARTICIPATION HEALTH HISTORY
PARENTAL AUTHORIZATION FORM
(Parent to Complete)

NAME ______________________________________ SCHOOL _________ ID #__________
(LAST NAME /FIRST Name)

This Health History form will be reviewed by the school nurse teacher, nurse practitioner or school physician prior to the physical exam. Please be prepared to give details regarding all yes answers.

YES NO HISTORY

___ ___ 1)Did you ever have a serious illness such as pneumonia, hepatitis, rheumatic fever, mononucleosis?
___ ___ 2) Have you ever had a serious injury requiring medical attention?
___ ___ 3) Are you prone to prolonged bleeding or do you have tendency to bleed?
___ ___ 4 Have you ever had bloody urine or bloody bowel movements?
___ ___ 5) Do you or have you ever had diabetes, asthma, jaundice, anemia, other?
___ ___ 6) Do you wear glasses or contact lenses?
___ ___ 7) Do you have sight in both eyes?
___ ___ 8) Do you have any hearing loss?
___ ___ 9) Do you have chronic coughing, wheezing or shortness of breath?
___ ___ 10) Have you ever had chest pain or tightness in chest while running?
___ ___ 11) Have you ever been told that you have heart disease or a heart murmur?
___ ___ 12) Have you ever been told you have high blood pressure?
___ ___ 13) Has any member of your family had a heart attack or heart trouble under the age of 50?
___ ___ 14) Have you ever been told you have an enlarged liver or spleen?
___ ___ 15) Do you have frequent or recurrent abdominal pain?
___ ___ 16 Have you ever been told you have a hernia or rupture?
___ ___ 17) Do you have persistent pains in any joint or in your arms or legs?
___ ___ 18) Have you ever had numbness, weakness or tingling in arms or legs?
___ ___ 19) Have you ever had a limp that lasted more than one week?
___ ___ 20) Have you ever had a knee or ankle injury that produced swelling /pain lasting longer than one week?
___ ___ 21) Have you ever fainted or been knocked out?
___ ___ 22) Have you ever had convulsions, fits or epilepsy?
___ ___ 23) Have you ever been told that you have kidney disease or a urinary tract infection?
___ ___ 24) Have you ever been in the hospital overnight for any reason?
___ ___ 25) Have you ever had surgery? (tonsils, appendix, etc.)
___ ___ 26) Are you allergic to any foods, medication or environmental factors?
___ ___ 27) Are you taking any medication? If yes, what medication______________.
___ ___ 28) Do you have trouble with fever blisters, boils or rashes?
___ ___ 29) Boys only: Do you have both testicles?
___ ___ 30) Girls only: Do you have any difficulty with your menstrual period? Date of last period___________.
___ ___ 31) Do you wear an orthodontic appliance? (Braces on your teeth)
___ ___ 32) Do you have any capped or false teeth?
___ ___ 33) What was the date of your last tetanus/diphtheria shot? ______________.

PARENT AUTHORIZATION

To the best of my knowledge this health history is correct and I hereby give permission to the school physician or his/her designee to examine my child for participation in school sports. We realize that there is a risk of being injured that is inherent in all sports. We realize the risk of injury may be severe, including the risk of fracture, brain injury, paralysis or even death.

Understanding the above, I give permission for my son/daughter _____________________ a student in the Newburgh Enlarged City School District to participate in ____________________ (insert name of the sport).

Address____________________________ Home Telephone_________ Cell__________

Parent/Guardian Signature_____________________________ Date_________________

Revised 12/07