

# HANNIBAL CENTRAL SCHOOL

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: \_\_\_\_\_

### IMMUNIZATION / 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"/> Immunization given since last Health Appraisals	Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done	Date: _____
Date of immunization _____	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: \_\_\_\_\_ Urine Protein: \_\_\_\_\_ Glucose: \_\_\_\_\_ 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 5" <input type="checkbox"/> 5" through 49" <input type="checkbox"/> 50" through 84"	Vision – Near Point	R	L
<input type="checkbox"/> 85" through 94" <input type="checkbox"/> 95" through 98" <input type="checkbox"/> 99" 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): \_\_\_\_\_

### 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 QUALIFICATIONS/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, 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  Sports 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

All sports physicals must be signed by school physician \_\_\_\_\_