

## Valley Stream Union Free School District Thirteen

*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).*

*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.*

### HEALTH APPRAISAL FORM

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Gender:** M F **Grade:** \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached      Sickle Cell Screen:  Positive  Negative  Not done      Date: \_\_\_\_\_  
 No immunizations given today      PPD:  Positive  Negative  Not done      Date: \_\_\_\_\_  
 Immunizations given since last Health Appraisal:  Elevated Lead:  Yes  No  Not done      Date: \_\_\_\_\_  
 Urine Analysis  Negative  Positive       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: \_\_\_\_\_  
 Referral: \_\_\_\_\_

Body Mass Index : \_\_\_\_\_

Weight Status Category (BMI Percentile):

less than 5<sup>th</sup>      5<sup>th</sup> through 49<sup>th</sup>      50<sup>th</sup> through 84<sup>th</sup>  
 85<sup>th</sup> through 94<sup>th</sup>      95<sup>th</sup> through 98<sup>th</sup>      99<sup>th</sup> and higher

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 \_\_\_\_\_

Specify any abnormality (use reverse side 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 OR only as checked:

\_\_\_\_\_ Limited contact: gymnastics, volleyball, handball, baseball, softball, dodge ball, pillow polo, kickball, basketball, soccer

\_\_\_\_\_ Non-contact: badminton, bowl, golf, tennis, dance, track, run, walk, jump rope, warm-up exercises, tumbling, jumping.

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: \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Phone: \_\_\_\_\_

Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ (stamp below)