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 5th 5th through 49th 50th through 84th
85th through 94th 95th through 98th 99th 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)