

*****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 Sickle Cell Screen: Positive Negative Not done Date: _____
 No immunizations given today PPD: _____ Please complete screening on reverse side of form
 Immunizations given since last Health Appraisal: (include dates) 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): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses	R	L	<i>Referral</i>
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	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: _____
 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:** _____

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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.

<input type="checkbox"/> Tylenol (pain, fever)	Dose _____	Freq. _____	Route _____
<input type="checkbox"/> Ibuprofen (Advil, Motrin) (pain, fever)	Dose _____	Freq. _____	Route _____
<input type="checkbox"/> Benadryl (Allergic reaction/Allergy)	Dose _____	Freq. _____	Route _____
<input type="checkbox"/> Antacid (Maalox, Tums) (abdominal discomfort)	Dose _____	Freq. _____	Route _____
<input type="checkbox"/> Cough Drops/Throat Lozenges (sore throat)	Dose _____	Freq. _____	Route _____
<input type="checkbox"/> 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.