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: _____

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

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