

# 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	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Vision - Near Point	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> 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 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 \_\_\_\_\_

**ATHLETIC PREPARTICIPATION HEALTH HISTORY  
PARENTAL AUTHORIZATION FORM  
(Parent to Complete)**

Address\_\_\_\_\_ Home Telephone\_\_\_\_\_ Cell\_\_\_\_\_

Parent/Guardian Signature\_\_\_\_\_ Date\_\_\_\_\_

Revised 12/07