

# Private Health Care Provider Form

## HEALTH APPRAISAL

### Newburgh Enlarged City School District

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ ID# \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_ Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

### IMMUNIZATIONS/SCREENING

Immunizations given since last Health Appraisal:       None given today       Immunization record attached

	1st	2nd	3 <sup>rd</sup>	4th	5th
<b>DtaP</b>	*	*	*		
<b>dT</b>	*	*	*		
<b>OPV/ IPV/eIPV</b>	*	*	*	**	
<b>HIB</b>	*	*			
<b>Hep B</b>	*	*	*		
<b>Varicella</b>	*	<input type="checkbox"/> Disease			
<b>MMR</b>					
<b>Other</b>					

SICKLE CELL SCREEN		Date
Positive	Negative	
PPD		Date
Positive	Negative	
LEAD SCREEN		Date
Positive	Negative	

PLEASE PROVIDE MO/D/YR FOR ALL; \* Required for entry to school in NYS: requirements may vary by age and grade; \*\* if IPV.

Vision—without glasses/contact lenses	R	L
Vision—with glasses/contact lenses	R	L
Vision—Near Point	R	L
Hearing	R	L

**Significant Medical/Surgical History**  check if additional reverse side \_\_\_\_\_

**Allergies:**  None  Food  Insect  Seasonal  Medication  LIFE THREATENING \_\_\_\_\_

### PHYSICAL EXAM

Height \_\_\_\_\_ Weight \_\_\_\_\_ Urine \_\_\_\_\_ B.P. \_\_\_\_\_ Pulse \_\_\_\_\_ Hct / Hgb \_\_\_\_\_

	Normal	Abnormal	Comments
General Appearance			
Nutrition/Body Mass Index		1-5: 1=Cachectic (BMI<17.5), 3=WNL (BMI 18.5-24.9), 5=Obese (BMI >29.9)	
Skin			
Head			
Eyes			
Ears			
Nose, Throat, Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen			
Genitalia			Tanner - I. II. III. IV. V.
Musculoskeletal			Scoliosis      Negative      Positive
Neurological			

Check here if entire exam is WNL or record **Diagnosis** \_\_\_\_\_

**Medication to be administered in school including Tylenol & Ibuprofen** check if  None or list all:

Name \_\_\_\_\_ Dosage/Time \_\_\_\_\_

Name \_\_\_\_\_ Dosage/Time \_\_\_\_\_

**PROVIDER'S SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_

**PROVIDER'S NAME / STAMP** \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

*I give permission for medication to be administered to my child in school as ordered by my health care provider.*

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_

NYS Education Department requires a physical exam for student entry into school at any grade level, for each student entering Pre K, K, students in the 2, 4, 7 & 10 grades, sports participation, working permits, and for the Committee on Special Education (CSE) triennial review. This exam complies with NYSED requirements. It is valid for one year through the last day of the month in which the physical was given except when the student has had an illness or injury lasting more than five days, which will negate this exam. The exam must be administered not more than 12 months prior to the start of the school year in which it is required, and the physical exam form presented within 30 days of entry into school or into any grade referenced above.