

**Scotia-Glenville Central School District
Scotia, New York**

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 (Please list any medications currently taking): 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: _____	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 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

NO SIGNIFICANT ABNORMALITIES IDENTIFIED ON EXAM

Specify any abnormality (use reverse of form if needed): _____

Tanner: I. II. III. IV. V. Scoliosis: Negative Positive

MEDICATIONS TO BE ADMINISTERED AT SCHOOL

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

Student may self carry and self administer medication Yes No

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

Student may self carry and self administer medication Yes No

Note: Nurse will 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 (specify): _____ Please monitor

Protective equipment required (specify): _____

Provider's Signature: _____ Phone: _____

Provider's Name/Address _____ Fax: _____

Parent Signature: _____ Date: _____

Reviewed by school medical director Signature: _____ Date: _____
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Providers please note:

New legislation in effect as of September 2008 requires that the Body Mass Index and the Weight Status Category (BMI Percentile) be determined by the Health Care Provider at the time of the physical exam for students entering grades in which a physical exam is required (Grades K, 2, 4, 7, 10 and all students new to the district.) Please make sure that the appropriate Weight Status Category is indicated on the physical form (or a supplemental form is completed); otherwise, the form will need to be returned to you for completion. Thank you for your cooperation.