

EAST IRONDEQUOIT SCHOOLS HEALTH APPRAISAL FORM

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 & 10, sports, working permits and triennially for the Committee on Special Education (CSE).

Name: _____
School: _____

Date of Birth: _____
Grade: _____

IMMUNIZATIONS/SCREENING

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

	1st	2nd	3rd	4th	5th
Diphtheria	*	*	*		
Tetanus	*	*	*		
Polio (type)	*	*	*	<i>*if IPV</i>	
MMR	*	*			
Hep B	*	*	*		
Varicella	*	<input type="checkbox"/> Disease			
HiB					

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

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

**-required for entry to school in NYS - requirements may vary by age and grade*

Significant Medical/Surgical History: see attached
Allergies: Food Insect Seasonal Medication **LIFE THREATENING**

PHYSICAL EXAM

Check here if entire exam normal Height: _____ Weight: _____ B.P.: _____
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		
Musculoskeletal		Tanner - I. II. III. IV. V.
Neurological		Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive

Medication (list all): None
Name: _____ Dosage/Time: _____
Name: _____ Dosage/Time: _____
If AM dose is missed at home: _____

I assess this student to be self directed and may self-carry medication Yes No (School nurse to also assess self-direction)
Please send in additional medication in the event that emergency sheltering is necessary at school.

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION/CSE CONSIDERATION

Physically qualified for sports or full playground OR only as checked below:
 Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, team handball, water polo, wrestling.
 Limited contact: baseball, cheerleading, cross-country, fencing, field, floor hockey, gymnastics, handball, skiing, softball, volleyball.
 Non-contact: archery, badminton, bowling, crew, dancing, golf, riflery, rope jumping, running, swimming, table tennis, tennis, walking, weight training.
 Knowledge based experience only.

Physically qualified for employment OR specify accommodation: _____
 Known or suspected disability: _____ Please monitor
 Restrictions: _____ Please monitor
 Protective equipment required: Athletic cup Glasses/eyewear Other: _____

This exam complies with NYSED requirements above and is valid for one year through the last day of the month dated below, with the exception of any illness or injury lasting more than five days that will negate this certification.

Provider's Signature: _____ Date of Exam: _____
 Phone: _____
 Provider's Name: _____ Fax: _____

PARENT: I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider:
 Parent Signature: _____ Date: _____

Please return to:
 Derech HaTorah of Rochester
 125 Kings Highway South
 Rochester, New York 14617
 Fax: 585-486-1089 / Phone: 585-266-2920