East Islip School District

HEALTH APPRAISAL FORM

New York State Education Department 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)

Name: _____Date of Birth: _____

School: _____Gender: □ M □ F Grade: _____

IMMUNIZATIONS/HEALTH HISTORY

□Immunization record attached:	**Sickle Cell Screen:**	**□Positive**	**□Negative**	**□Not Done**	**Date:**
□No immunizations given today:	**PPD:**	**□Positive**	**□Negative**	**□Not Done**	**Date:**
□Immunizations given since last Health Appraisal:	**Elevated Lead:**	**□Positive**	**□Negative**	**□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 □Other_____
□ Seasonal □ Insect □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	
□ 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 20db 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):

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

□ Free from contagious & 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, jump rope

□ 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.

Revised 6/11/08

East Islip School District

Student's Name: _____ ☐Male ☐ Female

Please indicate your preference below:

☐ I will be taking my child, _____, to our family physician and will submit copies of the updated physical to you by _____.
date

☐ Please schedule my child for a physical with the District doctor.

Parent/Guardian's signature: _____Date: _____

			Yes	No	Date
1.	**Any injuries requiring medical attention**		☐	☐	
2.	**Any illness lasting more than five (5) days**		☐	☐	
3.	**Taking any medicin e or under the care of a physician**		☐	☐	
4.	**Any feeling of dizziness, faintness or fatigue after heavy exertion**		☐	☐	
5.	**Wear glasses or contact lenses**		☐	☐	
6.	**A surgical operation or fracture**		☐	☐	
7.	**Treated in a hospital or Emergency Room**		☐	☐	
8.	**Any reason why this child cannot participate in any activity**		☐	☐	
9.	**Any known allergies**		☐	☐	
10.	**Any chronic disease**		☐	☐	
11.	**Head injury**		☐	☐	
12.	**Concussion**		☐	☐	
13.	**Eye Disorder**		☐	☐	
14.	**Ear Disorder**		☐	☐	
15.	**Nose Disorder**		☐	☐	
16.	**Throat Disorder**		☐	☐	
17.	**Dental Disorder**		☐	☐	
18.	**Heart:**	**Murmur**	☐	☐	
		Rheumatic Fever	☐	☐	
19.	**Lungs:**	**Pneumonia**	☐	☐	
		Bronchitis	☐	☐	
		Asthma	☐	☐	
20.	**Kidney, Bladder Disorder**		☐	☐	
21.	**Abdominal, Intestinal Disorder**		☐	☐	
22.	**Hernia**		☐	☐	
23.	**Undecended Testicles**		☐	☐	
24.	**Bones, Joints:**	**Fractures**	☐	☐	
		Dislocations	☐	☐	
		Other	☐	☐	
25.	**Muscle, Nerve Disorder**		☐	☐	
26.	**Hospital Admissions**		☐	☐	
27.	**Seizures**		☐	☐	
28.	**Diabetic**		☐	☐	

If you have answered yes to any of the above questions, please explain on back.

Signature: _____Date: _____

Student's Name _____ **School:** _____