Clarence Central School District
HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____ Grade: _____

School: _____ Gender: ❑M ❑ F

IMMUNIZATIONS / HEALTH HISTORY

☐ No immunizations given today Dental Referral: ☐ Yes ☐ No Date: _____ Sickle Cell Screen ☐ Positive ☐Negative Date: _____
☐ Immunization record attached Lead Screening: ☐ Yes ☐ No Date: _____ PPD ☐ Positive ☐Negative Date: _____

Significant Medical/Surgical History: ☐ See attached _____

_____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Asthma Severity: ☐ Dormant ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Inhaler _____

Allergies: ☐ **LIFE THREATENING** ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____ ☐ Food: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Pulse: _____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	Hearing ❑ Pass 20 db sc both ears or:	R	L	
❑85th through 94th ❑ 95th through 98th ❑ 99th and higher				

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: ☐ *Referral Given*

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

_____

_____

MEDICATIONS

Medications: ☐ None

Name: _____ Dose/Time_____ ☐ given at home ☐given at school

Name: _____ Dose/Time_____ ☐ given at home ☐given at school

I assess this student to be self-directed ☐ Yes ☐ No Student may 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 not has been given.

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

☐ **Free from contagions & physically qualified for all physical education, sports, playground** ☐ **Physically qualified for work**
___ Contact/Collision: Restrict: _floor hockey, _football, _lacrosse, _soccer, handball, Group Games *Order expires*_____
___ Limited contact: Restrict: _basketball _kickball _softball _ultimate Frisbee _volleyball, _snowshoeing *Order expires*_____
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, Kan Jam, weight train, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school**: _____ ☐ none

☐ **Restrictions:** _____ ☐ **Seizure Precautions:** No climbing over 6', no unattended swimming.

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

NYS Education Department requires an annual physical exam for new entrants, students in Grades K, 1, 3, 5, 7, 9 and 11, sports, working permits, and, triennially, for the Committee on Special Education (CSE). This exam 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 exam.

2/2018