

HEALTH APPRAISAL FORM

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

IMMUNIZATIONS/SCREENING

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

	1st	2nd	3rd	4th	5th
DTaP	*	*	*		
Polio: (type)	*	*	*	<i>*if IPV</i>	
HIB					
Latest tetanus:					
Hep B	*	*	*		
MMR	*	*			
Varivax	*	<input type="checkbox"/> Disease			
Pneumococcal					

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*

1. Significant Medical/Surgical History:

2. Allergies:

3. Medication taken regularly:

PHYSICAL EXAM

Height: _____ Weight: _____ B.P.: _____ Resting Pulse: _____

Check here if entire exam normal

	Normal	Abnormal	Comments
General appearance			
Nutrition			1-5: 1=Cachectic, 3=WNL, 5=Obese
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			

4. Medication: None Medication at home only Medication to be given at school:

Name: _____

Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self directed and may self-carry medicator Yes No

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION

Physically qualified for sports or full playground as indicated below

___ Contact/Collision: basketball, boxing, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, jumping

___ Non-contact/strenuous: cheerleading, field, gymnastics, skiing, volleyball, track & field, cross-country, handball, running

___ Non-strenuous: badminton, bowling, golf, swimming, table tennis, tennis, archery, riflery.

___ Knowledge based experience only.

Physically qualified for employment

Known or suspected disability: _____

Restrictions: _____

Provider's Name: _____

Phone: _____

Provider's _____

Date: _____

Signature: _____

Fax: _____

PLEASE RETURN TO SCHOOL NURSE AT _____