

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).

PRIVATE PHYSICIAN PHYSICAL HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____
 School: **Fallsburg Central School District** Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached
 No Immunizations given today
 Immunizations given since last Health Appraisal:
*****SEE BACK OF FORM*****
- Sickle Cell Screen: Positive Negative Not Done Date: _____
 PPD: Positive Negative Not Done Date: _____
 Elevated Lead: Positive Negative Not Done Date: _____
 Dental Referral: Positive Negative 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: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____
Referral

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5" <input type="checkbox"/> 5" through 49" <input type="checkbox"/> 50" through 84" <input type="checkbox"/> 85" through 94" <input type="checkbox"/> 95" through 98" <input type="checkbox"/> 99" and higher	Vision – without glasses /contact lenses Vision – with glasses/ contact lenses Vision – Near Point Hearing <input type="checkbox"/> Pass 20 db sc both ears or :	R R R R	L L L L	
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EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

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

MEDICATIONS

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

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

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

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, baseball, floor hockey, softball.
 _____ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, weight train, dance, track run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective Equipment required: Athletic Cup Sports 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 reviews by private healthcare provider and the school medical director.

FALLSBURG CENTRAL SCHOOL DISTRICT

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Updated Immunizations	#1	#2	#3	#4	#5
DPT					
Tdap					
Td					
MMR					
Varicella					
Hepatitis A series					
Hepatitis B					
Polio (IPV, OPV)					
HPV					
Haemophilus influenzae type b (HIB)					
Pneumococcal Conjugate (PCV)					
Meningococcal Conjugate					