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: _____	Vision – without glasses /contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision – with glasses/ contact lenses	R	L	
☐ less than 5" ☐ 5" through 49" ☐ 50" through 84"	Vision – Near Point	R	L	
☐ 85" through 94" ☐ 95" through 98" ☐ 99" and higher	Hearing ☐ Pass 20 db 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): _____

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 asses 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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Fax: 845-434-3821

Merriam Hobby, RN, School Nurse
Benjamin Cosor Elementary School
PO BOX 123
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Fax: 845-434-0871

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					