

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and Annual & Program Reviews and Reevaluations for the Committee on Special Education (CSE)

**\*\*\*PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

**CITY SCHOOL DISTRICT OF NEW ROCHELLE  
HEALTH APPRAISAL FORM      Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_

**IMMUNIZATIONS / HEALTH HISTORY**

- Immunization record attached      Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
 No immunizations given today      PPD: \_\_\_\_\_ Please complete screening on reverse side of form  
 Immunizations given since last Health Appraisal: (include dates)      Elevated Lead:  Yes  No  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: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal       Medication: \_\_\_\_\_

**PHYSICAL EXAM**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Body Mass Index: _____ (Required by NYS)	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Vision - Near Point	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

**EXAM ENTIRELY NORMAL**      Tanner: I. II. III. IV. V.      Scoliosis:  Negative  Positive: \_\_\_\_\_  
 For Girls: Age of onset of menses: \_\_\_\_\_ LMP: \_\_\_\_\_  
 Specify any abnormality (use separate paper if needed): \_\_\_\_\_

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

- Free from contagions & 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, rope jump.  
 **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: \_\_\_\_\_

**SPORTS CLEARANCE:** By signing and submitting this form, the parent and physician attest that they have fully disclosed all of this student's health history, conditions, medications and relevant family history (e.g., early cardiac death.) Parent and physician assume liability for non-disclosures of such information. The School District Physician has final authority to medically clear students for interscholastic sports participation.

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 \*\*\*Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

**TUBERCULOSIS TESTING / SCREENING - EITHER A OR B MUST BE COMPLETED BY THE PHYSICIAN**

**A. PPD (Mantoux):**

1. Date placed \_\_\_\_\_ Date read \_\_\_\_\_ Result in mm \_\_\_\_\_

2. If PPD is Positive: CXR: \_\_\_\_\_ Date of exam: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_

Treatment: \_\_\_\_\_  
\_\_\_\_\_

**B. Tuberculin screening not indicated \_\_\_\_\_ (MD must initial)**

**PRESCRIPTION MEDICATIONS**

Medications (list all):  None

Medication: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Medication: \_\_\_\_\_ 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. \*Students are not permitted to carry or self-administer USDEA controlled drugs. 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.

**PERMISSION TO RECEIVE PRESCRIPTION AND OVER THE COUNTER (OTC MEDICATION)**

**Health Care Provider and Parent signatures required  
Parents must provide all medications.**

- |  |            |               |             |
|--|------------|---------------|-------------|
| <input type="checkbox"/> Tylenol (pain, fever)                         | Dose _____ | Freq. _____   | Route _____ |
| <input type="checkbox"/> Ibuprofen (Advil, Motrin) (pain, fever)       | Dose _____ | * Freq. _____ | Route _____ |
| <input type="checkbox"/> Benadryl (Allergic reaction/Allergy)          | Dose _____ | Freq. _____   | Route _____ |
| <input type="checkbox"/> Antacid (Maalox, Tums) (abdominal discomfort) | Dose _____ | Freq. _____   | Route _____ |
| <input type="checkbox"/> Cough Drops/Throat Lozenges (sore throat)     | Dose _____ | Freq. _____   | Route _____ |
| <input type="checkbox"/> Antibiotic Ointment (skin lesions)            | Dose _____ | Freq. _____   | Route _____ |

**SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE  
TO DISPENSE PRESCRIPTION AND OTC MEDICATION**

(Stamp below)

Provider's Signature: \_\_\_\_\_

Phone: \_\_\_\_\_

Provider's Name/Address: \_\_\_\_\_

Fax: \_\_\_\_\_

\*\*\*Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_