BYRAM HILLS CENTRAL SCHOOL DISTRICT

New York State requires an annual physical exam for (1) new entrants, (2) students in Grades K, 2, 4, 7 and 10, (3) sports, (4) working permits and (5) Annual & Program Reviews and Reevaluations for the Committee on Special Education (CSE)

***PARENTS! BOTH YOU AND YOUR CHILD'S HEALTH CARE PROVIDER MUST SIGN AND DATE BOTH SIDES OF THIS FORM

HEALTH APPRAISAL FORM

Date of Exam: ___/___/___

Name: _____ **Date of Birth:** ___/___/___ **Gender**: ❑ M ❑ F

School: _____ Grade: ____

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal: (include dates)

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: _____
PPD: Please complete screening on reverse side of form
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)

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ Pass 20 db sc both ears or:	R	L	

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

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE AND 504 CONSIDERATIONS

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerleading, gymnastics, skiing, volleyball, cross-country, fencing, baseball, floor hockey, softball. Other: _____
___ Non-contact: badminton, golf, swimming, tennis, archery, weight training, dancing, track, running, walking, rope jumping. Other: _____
❑ **Specify medical accommodations and / or precautions 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.) Non-disclosures of such information may place a student at risk and are subject to liability. 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! BOTH YOU AND YOUR CHILD'S HEALTH CARE PROVIDER MUST SIGN AND DATE BOTH SIDES OF THIS FORM

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.

❒ Tylenol (pain, fever)	Dose _____	Freq._____	Route_____
❒ Ibuprofen (Advil, Motrin) (pain, fever)	Dose _____	Freq._____	Route_____
❒ Benadryl (Allergic reaction/Allergy)	Dose _____	Freq._____	Route_____
❒ Antacid (Maalox, Tums) (abdominal discomfort)	Dose _____	Freq._____	Route_____
❒ Cough Drops/Throat Lozenges (sore throat)	Dose _____	Freq._____	Route_____
❒ Antibiotic Ointment (skin lesions)	Dose _____	Freq._____	Route_____
❒ Other _____	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:** _____