COLD SPRING HARBOR CENTRAL SCHOOL DISTRICT

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).

HEALTH APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ☐ M ☐ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
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: _____ _____ . _____

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: _____

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

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of 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 contagions & physically qualified for all physical education, sports, playground, work & school activities**

☐ **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: _____

(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 review by private healthcare provider and the school medical director. *Rev. 10/3/07*

Grades 7-12: For Interscholastic Competitive Activities, complete side 2

Form I

Name_____ Sex M___F___Grade____ Sport_____

SPORTS CANDIDATE HEALTH HISTORY

1. Have you ever had any fractures, dislocations, severe sprains or serious injuries?.....Yes_____ No_____
2. Have you ever been hospitalized?.....Yes_____ No_____
3. Have you ever had surgery?.....Yes_____ No_____
4. Do you have any allergies?.....Yes_____ No_____
5. Do you take any medications now?.....Yes_____ No_____
6. Have you ever been refused permission to participate in athletics?.....Yes_____ No_____
7. Have you ever experienced any type of head injury or concussion?.....Yes_____ No_____
8. Do you wear glasses?_____ Contact Lenses?_____

Please explain any "yes" answers to the questions above:

_____

_____

This certifies that the above mentioned student is physically qualified to participate in the following categories of competition this school year.

Contact	Limited Contact	Non-Contact	Moderately Strenuous	Non-Strenuous
Yes___ No___	Yes___ No___	Yes___ No____	Yes___ No___	Yes___ No___
Floor Hockey	Baseball	Aerobic Exercise	Bowling	Archery
Football	Basketball	Badminton	Golf	Board Games
Ice Hockey	Fencing	Crew	Recreational Games	Computer Games
Lacrosse (Boys)	Field Hockey (Girls)	Cross Country	Table Tennis	
Wrestling	Gymnastics	Jogging		
	Lacrosse (Girls)	Paddleball		
	Soccer	Relays		
	Softball	Swimming		
	Team Football	Tennis		
	Touch Football	Track & Field		
	Ultimate Frisbee	Weight Training		
	Cheerleading	Volleyball		

Reason for disqualification_____

_____

Date_____ PHYSICIAN_____

This certificate is void if the pupil is absent from school five (5) or more days because of illness or because of a significant injury. He/She must be re-certified before participation again.