

ICHABOD CRANE CENTRAL SCHOOL HEALTH APPRAISAL FORM

CO-43

Name: _____ Date of Birth: _____ Gender: M F
Address: _____ 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: _____ U/A glucose _____ protein _____ Date of Exam: _____

Table with 4 columns: Body Mass Index, Weight Status Category (BMI Percentile), Vision - without glasses/contact lenses, Vision - with glasses/contact lenses, Vision - Near Point, Hearing. Includes checkboxes for exam status and scoliosis.

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 OR only as checked:
Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
Non-contact: badminton, bowl, golf, swim, tennis, archery, weight train, crew, dance, track, run, walk, rope jump, marching band
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