

NICHOLS SCHOOL HEALTH APPRAISAL FORM

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

IMMUNIZATIONS/SCREENINGS

- Immunizations given since last Health Appraisal None given today Immunization record attached

	1 st	2 nd	3 rd	4 th	5 th
DTap					
Polio (type)					
Hib					
Pneumococcal					
Varicella			=Disease		
MMR					
Heptatis B					

SICKLE CELL SCREEN		Date
Positive	Negative	
PPD		Date:
Positive	Negative	
LEAD SCREEN		Date:
Positive	Negative	

Vision-without glasses/contact lenses	R	L
Vision- with glasses/contact lenses	R	L
Hearing	R	L

MEDICAL HISTORY

Significant Medical/Surgical History: _____ see attached
 Allergies: _____ No known Allergies
 Medications: _____
 Medications (To be administered at school): _____ None
 Name: _____ Dosage/Time: _____
 Name: _____ Dosage/Time: _____
 I assess this student to be self directed and may self-carry medication YES NO (School nurse to also assess self-direction)
 Parent's Name: _____ Parent's Signature: _____

PHYSICAL EXAM

Check here if entire exam normal Height: _____ Weight: _____ BMI: _____ BP: _____

	Normal	Abnormal	Comments
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Head	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	
Nose, Throat & Teeth	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph Nodes/Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Tanner – I, II, III, IV, V _____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis: Negative _____ Positive _____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	

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

- Physically qualified for sports or full playground OR only as checked below:**
 ___ Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water polo.
 ___ Limited contact: cheerleading, field, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowling, golf, swimming, table tennis, tennis, weight training, crew, dancing, track, running, walking, rope jumping.
 ___ Knowledge based experience only.
 Free from contagious and communicable disease and is able to participate in PE/Sport
 Physically qualified for employment OR specify accommodation: _____
 Known or suspected disability: _____ Please Monitor
 Restrictions: _____ Please Monitor
 Protective equipment required; Athletic cup Glasses/eyewear other: _____

This exam complies with NYSED requirements above and is valid for one year through the last day of the month dated below, with the exception of any illness or injury lasting more than five days that will negate this certification

Provider's Signature: _____

Date: _____

Provider's Name: _____