

School: \_\_\_\_\_

Grade: \_\_\_\_\_

**HEALTH APPRAISAL FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

**IMMUNIZATIONS/SCREENING**

Immunizations record attached     Immunizations given since last health appraisal     None given today

	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>		
<b>DTaP</b>	*	*	*					
<b>TD</b>								
<b>Polio (type)</b>	*	*	*	<i>*If IPV</i>				
<b>HIB</b>								
<b>Hep B</b>	*	*	*					
<b>MMR</b>	*	*						
<b>Varivax</b>	*						<input type="checkbox"/> Disease Date: _____	
<b>Pneumococcal</b>								
<b>Other</b>								

  

<b>SICKLE CELL SCREEN</b>		Date:
Positive	Negative	
<b>PPD</b>		Date:
Positive	Negative	
<b>LEAD SCREEN</b>		Date:
Level:		

  

Vision – without glasses/contact lenses	R	L
Vision – with glasses/contact lenses	R	L
Vision – Near Point	R	L
Hearing	R	L

*\* Required for entry to school in NYS - requirements may vary by age and grade*

**1. Significant Medical/Surgical History:**

\_\_\_\_\_

**2. Allergies and Reaction:**

\_\_\_\_\_

**PHYSICAL EXAM**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B.P.: \_\_\_\_\_ Resting Pulse: \_\_\_\_\_

Check here if entire exam normal

	Normal	Abnormal
General appearance	_____	_____
Nutrition	_____	_____
Skin	_____	_____
Head	_____	_____
Eyes	_____	_____
Ears	_____	_____
Nose, Throat & Teeth	_____	_____
Lymph Nodes/Thyroid	_____	_____
Lungs	_____	_____
Heart	_____	_____
Abdomen	_____	_____
Genitalia	_____	_____
Musculoskeletal	_____	_____
Neurological	_____	_____

**Body Mass Index:** \_\_\_\_\_ - \_\_\_\_\_

**Weight Status Category (BMI Percentile):**

Less than 5<sup>th</sup>     5<sup>th</sup> through 49<sup>th</sup>     50<sup>th</sup> through 84<sup>th</sup>  
 85<sup>th</sup> through 94<sup>th</sup>     95<sup>th</sup> through 98<sup>th</sup>     99<sup>th</sup> and higher

**Associated Health Conditions:**

Asthma     Diabetes, Type 1     Hyperlipidemia  
 Hypertension     Diabetes, Type 2

Tanner – I. II. III. IV. V.

<b>Scoliosis:</b>	Negative	Positive
<b>Urine:</b>	<b>Protein</b>	<b>Glucose</b>

**4. Medication:**

None     Medication at home only     Medication to be given at school:

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

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

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed and may self-carry medication     Yes     No

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

Physically qualified for sports or full playground as indicated below:

- \_\_\_\_\_ Contact/Collision: basketball, boxing, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, jumping
- \_\_\_\_\_ Non-contact/strenuous: cheerleading, field, gymnastics, skiing, volleyball, track & field, cross-country, handball, running
- \_\_\_\_\_ Non-strenuous: badminton, bowling, golf, swimming, table tennis, tennis, archery, riflery
- \_\_\_\_\_ Knowledge based experience only

Physically qualified for employment

Known or suspected disability: \_\_\_\_\_

Restrictions: \_\_\_\_\_

**Provider's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Provider's Signature:** \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_

**KENDALL CENTRAL SCHOOL**  
KENDALL, NEW YORK 14476

**PARENTS, PLEASE ANSWER THE QUESTIONS BELOW:**

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Medical History**

1. Were there any complications surrounding the pregnancy, labor, or delivery time with your child?  
\_\_\_\_\_

2. Has he/she had any:

a. serious illness/es?      Yes      No      Please list with approximate date. \_\_\_\_\_

b. childhood diseases?      (please circle)      Verified by doctor      approximate date  
    chicken pox      Yes      No      Yes      No      \_\_\_\_\_

c. serious accidents?      Yes      No      Please list with approximate date. \_\_\_\_\_

d. allergies?      Yes      No      Please list and describe reaction if exposed: \_\_\_\_\_

e. been hospitalized?      Yes      No      had any surgery?      Yes      No  
    Please list when and why: \_\_\_\_\_

f. head injuries? \_\_\_\_\_

3. Does he/she take any medicine?      Yes      No      If so, what kind? \_\_\_\_\_

4. Is he/she frequently ill?      Yes      No      If so, type of illness? \_\_\_\_\_

5. Does he/she have any visual problems?      Yes      No      Wear eyeglasses?      Yes      No

6. Does he/she have any known hearing difficulties? Yes      No      If so, please explain. \_\_\_\_\_

7. Does he/she have any dental problems? Yes      No      If so, please explain. \_\_\_\_\_

8. Does he/she have any artificial parts (i.e. eye, limb, dental, etc.)?      Yes      No      If so, please list \_\_\_\_\_

9. Has your child had any problems (physical or emotional) for which you have sought outside help? Yes      No  
    If so, from what source? \_\_\_\_\_

Physician's Name \_\_\_\_\_

Dentist's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Phone Number \_\_\_\_\_

Address: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospital Used: \_\_\_\_\_

Other Concerns, Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_