

SCHOHARIE CENTRAL SCHOOL 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: _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	+
	Hearing <input type="checkbox"/> 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, play-ground, 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, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

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: _____

Sports _____ Homeroom # _____

PART A – HEALTH HISTORY OF ATHLETE:

(To be completed by athlete and parent)

EXPLAIN ANY “YES” ANSWERS

	YES	NO
Have you ever had an injury that:		
a. required you to go to an emergency room or see a doctor?	_____	_____
b. required you to stay in the hospital?	_____	_____
c. required x-rays?	_____	_____
d. caused you to miss 3 days of practice or a competition?	_____	_____
e. required an operation?	_____	_____

Have you ever had an illness that:		
a. required you to stay in the hospital?	_____	_____
b. lasted longer than a week?	_____	_____
c. caused you to miss 3 days of practice or a competition?	_____	_____
d. is related to allergies? (i.e. hay fever, hives, asthma, insect stings)	_____	_____
e. required an operation?	_____	_____
f. Is chronic? (i.e. asthma, diabetes, etc.)	_____	_____

Do you take any medication or pills? _____

List: _____

Have any members of your family under age 50 had a heart attach, heart problem, or died unexpectedly? _____

Have you ever had a heart murmur, high blood pressure or a heart abnormality? _____

Have you ever:

a. been dizzy or passed out during or after exercise?	_____	_____
b. unconscious or had a concussion?	_____	_____

Are you missing a kidney? _____

When was your last tetanus booster? _____

Are you able to run 1/2 mile (2 times around the track) without stopping? _____

Do you:

a. wear glasses or contacts?	_____	_____
b. wear dental bridges, plates or braces?	_____	_____

For women:

a. At what age did you experience your first menstrual period? _____
b. In the last year, what is the longest time you have gone between periods? _____

I hereby state, that to the best of my knowledge, my answers to the above questions are correct.
Date _____

Signature of Athlete _____

Signature of Parent _____