

Grade: _____

HEALTH APPRAISAL FORM

School: _____

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).

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

IMMUNIZATIONS / SCREENING

<input type="checkbox"/> Immunizations given since last Health Appraisal:					<input type="checkbox"/> None given today		<input type="checkbox"/> Immunization record attached		
	1st	2 nd	3 rd	4 th	5th	SICKLE CELL SCREEN			Date:
DPT	*	*	*			Positive	Negative		
Tetanus						PPD			Date:
Polio (type)	*	*	*		*if IPV	Positive	Negative		
MMR	*	*				LEAD SCREEN			Date:
Hep B	*	*				Positive	Negative		
Varicella	*	<input type="checkbox"/> Disease							Referral
HIB	*					Vision - without glasses/contact lenses	R	L	
						Vision - with glasses/contact lenses	R	L	
						Vision - Near Point	R	L	
						Hearing	R	L	

Significant Medical/Surgical History: See attached _____

Allergies: Food Insect Seasonal Medication LIFE THREATENING

PHYSICAL EXAM

Check here if entire exam normal Height: _____ Weight: _____ Blood Pressure: _____

	Normal	Abnormal	Comments
General appearance			
Nutrition/Body Mass Index		1-5: 1=Cachectic (BMI<17.5), 3=WNL (BMI 18.5-24.9), 5=Obese (BMI>29.9)	
Skin			
Head			
Eyes			
Ears			
Nose, Throat and Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen			
Genitalia			
Musculoskeletal			
Neurological			
			Tanner - I. II. III. IV. V.
			Scoliosis: Negative Positive

Medication (list all): None Permission for 2 tabs Tylenol or Ibuprofen to be given by the school nurse every 4 hours prn

Name: _____ Dosage/Time: _____

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 (School nurse to also assess self-direction)

Please 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

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 hockey, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softball.

___ Non-contact: badminton, bowling, golf, swimming, table tennis, tennis, archery, riflery, weight training, crew, dancing, track, running, walking, rope jumping.

___ Knowledge based experience only.

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/Address: _____ Phone: _____

Fax: _____

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays. If your child requires medication in school, please sign the permission below.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) listed below to release the medical records of my child, _____, district's medical officer, school nurse, Occupational Therapist (OT), Physical Therapist (PT) or Speech Therapist (ST):

Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____

The healthcare provider may disclose the following protected health information: (check all that apply)

- Immunizations
- Health Appraisals
- Past/Current Medical Condition and Its Impact on Attendance or School Programming or need for therapy
- Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery or therapy prescriptions
- At patient's request with no specified purpose
- Other _____

Please select one:

- This authorization is valid for the entire academic school year 20 - 20
- This authorization shall expire on ____/____/____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date _____ Signature of Patient (Over 18), Parent, or Guardian _____ Relationship _____
YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
 A signed copy of this authorization must be given to the adult patient or parent of the minor child

I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider.

Name _____ Date _____