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: ______ ______ . ______

Weight Status Category (BMI Percentile):

☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th

☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	+
Hearing 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:_______________________

Name____Age_______(YRS) Grade_____Date________________

Sports____Homeroom # ______________

PART A – HEALTH HISTORY OF ATHLETE:
(To be completed by athlete and parent)

	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:___________________________________
____

	YES	NO
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 ½ 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?

EXPLAIN ANY "YES" ANSWERS

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______________________________________