

# HEALTH APPRAISAL

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

## IMMUNIZATIONS/SCREENING

Immunizations given since last Health Appraisal:

None given today

Immunization record attached

	1st	2nd	3 <sup>rd</sup>	4th	5th
<b>DTaP</b>	*	*	*		
<b>dT</b>	*	*	*		
<b>OPV/IPV/eIPV</b>	*	*	*	**	
<b>HIB</b>	*	*	*		
<b>Hep B</b>	*	*	*		
<b>Varicella</b>	*	<input type="checkbox"/> Disease			
<b>MMR</b>					
<b>Other</b>					

<b>SICKLE CELL SCREEN</b>		Date
Positive	Negative	
<b>PPD</b>		Date
Positive	Negative	
<b>BLOOD LEAD TEST</b>		Date
mcg/dL		

PLEASE PROVIDE MO/D/YR FOR ALL; \* Required for entry to school in NYS: requirements may vary by age and grade; \*\* if IPV.

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:**  None  Food  Insect  Seasonal  Medication  LIFE THREATENING \_\_\_\_\_

## PHYSICAL EXAM

Check here if entire exam normal

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

	Normal	Abnormal	Comments
General Appearance			
Nutrition/Body Mass Index		BMI = / %	
Skin			
Head			
Eyes			
Ears			
Nose, Throat, Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen			
Genitalia			Tanner - I. II. III. IV. V.
Musculoskeletal			Scoliosis Negative Positive
Neurological			

**Medication** (list all):  None

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  No  Yes (School nurse to also assess self-direction)

Please send in additional medication in the event that emergency sheltering is necessary at school.

## 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, bowl, golf, swim, table tennis, tennis, archery, riflery, weights, crew, dance, track, running, walking, jump rope

\_\_\_\_ 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/ sport eyewear  Other \_\_\_\_\_

NYS Education Department requires an annual physical exam for new entrants, students in Grades K, 1, 4, 7 & 10, sports, working permits, and, triennially, for the Committee on Special Education (CSE). 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 exam.

**PROVIDER'S SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_

**PROVIDER'S NAME** \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

I give permission for medication to be administered to my child as ordered by my health care provider. I give permission for photographs to be taken of my child to be used on the medication bottle and log.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_

Since April 2003, HIPPA (Health Insurance Portability and Accountability Act) requires your healthcare provider to have the form below completed to share protected health information with the school district. Schools are required to have a signed parent release under FERPA (Family Educational Records Privacy Act). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

**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, \_\_\_\_\_, to the district's  
 Medical Officer,  School Nurse,  Occupational Therapist (OT),  Physical Therapist (PT),  
 Speech Therapist (ST),  Athletic Trainer (AT),  Psychologist,  Social Worker,  Counselor, or  other (specify) \_\_\_\_\_

Parent, list all your child's healthcare providers below:

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

The healthcare provider may disclose the following protected health information: (school and/or parent: check all that apply):

- Immunizations
- Health Appraisals
- Past/Current Medical Condition and Its Impact on Attendance, Athletics, or School Programming or therapy(ies)
- Other

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

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational, school, or athletic 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 \_\_\_\_\_

Parent, please select one (Note: if you do not sign for the complete academic year, you may need to complete another form, as needed):

- 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. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

\_\_\_\_\_  
 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**