

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).

Mahopac Central School District  
HEALTH APPRAISAL FORM

This form MUST be filled out in its entirety  
THIS FORM AND ALL ATTACHMENTS MUST BE SIGNED AND STAMPED TO BE VALID

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

School: \_\_\_\_\_ Gender:  M  F Grade/Teacher: \_\_\_\_\_

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached/on reverse side of this form  
 No immunizations given today  
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  Pre hypertensive  Hypertension  
 Other: \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

If any medications are needed, a current medications slip MUST be on file in the health office for the current school year

PHYSICAL EXAM: ALL sections MUST be filled out

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Referral

Body Mass Index: _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Vision - Near Point	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	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 \_\_\_\_\_

MEDICATIONS

Medications  None

List medications taken at home: \_\_\_\_\_  
\_\_\_\_\_

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**IMMUNIZATIONS: Please give type and full date (Month/Day/Year)**

DPT/DTaP #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_

**Tdap** \_\_\_\_\_

HIB #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

OPV #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

IPV #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Live Measles, Mumps, Rubella (MMR) \_\_\_\_\_ MMR Booster \_\_\_\_\_

If given separately, Measles #1 \_\_\_\_\_ Measles #2 \_\_\_\_\_ Rubella \_\_\_\_\_ Mumps \_\_\_\_\_

Hepatitis A Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Hepatitis B Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

GARDASIL/HPV #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Varicella Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_ Varicella Disease \_\_\_\_\_

PPD \_\_\_\_\_ results \_\_\_\_\_

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

**Free from contagions & physically qualified for all physical education, sports, playground, 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.

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**THIS FORM AND ALL ATTACHMENTS MUST BE STAMPED AND SIGNED BY PROVIDER:**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DENTAL HEALTH**

**REQUESTED BY NEW YORK STATE EDUCATION LAW**

Student \_\_\_\_\_ Grade \_\_\_\_\_

Please have your child checked by your family dentist.

Under treatment \_\_\_\_\_ Completed \_\_\_\_\_

No Treatment Needed \_\_\_\_\_ Date \_\_\_\_\_

**THIS FORM MUST BE STAMPED BY PROVIDER:**

Dentist's Signature \_\_\_\_\_

**THIS PHYSICAL EXAMINATION/DENTAL HEALTH FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL NURSE WITHIN 30 DAYS OF BEGINNING SCHOOL. IF YOUR CHILD HAS A SCHEDULED APPOINTMENT PLEASE MAKE THE SCHOOL NURSE AWARE OF THE APPOINTMENT DATE.** The school physician will examine all students in the above mentioned grades for whom we do not have a record of exam by the family physician.

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