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	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	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 _____

_____

_____

MEDICATIONS

Medications ☐ None

List medications taken at home: _____

_____

(OVER)

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider. *Rev. 11/09*

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).

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.

(OVER)

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider. *Rev. 11/09*