

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 Other: _____ Diabetes: Type 1 Type 2 Pre hypertensive Hypertension

Allergies: LIFE THREATENING Seasonal Food: _____ Medication: _____ Insect: _____ Other: _____

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 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th 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: _____

(OVER)

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)