

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).

HICKSVILLE SCHOOLS HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____
 School: _____ Gender: M F Grade: _____

HEALTH HISTORY

(Parent Circle Yes or No)

- | | | |
|---|-----|----|
| 1. Has your child ever had any fractures, dislocations, severe sprains or serious injuries? | Yes | No |
| 2. Has your child ever been hospitalized or treated in an emergency room? | Yes | No |
| 3. Has your child ever had surgery? | Yes | No |
| 4. Has your child any allergies ___ Seasonal; ___ Life threatening; ___ Asthma; ___ Medication | Yes | No |
| 5. Does your child take any medication now? | Yes | No |
| 6. Has your child ever experienced any type of head injury or concussion? | Yes | No |
| 7. Has your child had any chronic disease? | Yes | No |
| 8. Does your child have a heart murmur, high blood pressure extra heartbeat or any heart abnormality? | Yes | No |

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BELOW:

To the best of my knowledge, the above information is correct:

Parent/Guardian Signature _____ Date: _____

PHYSICAL EXAM TO BE COMPLETED BY PHYSICIAN

- | | | |
|---|--|-------------|
| <input type="checkbox"/> Immunization record attached | Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done | Date: _____ |
| <input type="checkbox"/> No immunizations given today | Dental Referral <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done | Date: _____ |
| <input type="checkbox"/> Immunizations given since last Health Appraisal: | | |

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: _____

Height:	Blood Pressure:	Pulse:
Weight:	Abdomen:	
Eyes:	Hernia:	
Ears:	Heart:	
Vision:	Lungs:	
Nose & Throat:	Orthopedic:	
Mouth & Teeth:	Scoliosis:	
Skin:	Other:	

Student requires medication? Yes ___ No ___. If yes, please specify:

Student may carry inhaler and self-administer: Yes ___ No ___ I assess this student to be self-directed: Yes ___ No ___

Referral

Body Mass Index: _____ . _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses	R	L	
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities

Provider's Stamp below:

Provider's Signature: _____

Actual Date of Examination: _____

(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 and the school medical director. Rev. 10/3/07

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IMMUNIZATION RECORD TO BE COMPLETED BY PHYSICIAN

Immunizations	Date 1 st dose	Date 2 nd dose	Date 3 rd dose	Date 1 st booster	Date 2 nd booster	Date 3 rd booster
Polio						
DPT						
TD or DT						
Tdap						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis B						
Varicella						
Pneumococcal						
Meningococcal						
PPD (Tuberculin)						
Hepatitis A						
Lead						
Other						

Legal requirement for immunization waived because of: Religious exemption _____ Medical exemption _____

PHYSICAL EDUCATION | SPORTS | PLAYGROUND | WORK QUALIFICATION | CSE CONSIDERATION

DISPOSITION: Full Unlimited Participation _____ in all sports listed below:

May the student participate in the following interscholastic sports?

Contact Sports: Yes ____ No ____

(Football, Lacrosse (boys), Wrestling)

Limited Contact Sports: Yes ____ No ____

(Basketball, Baseball, Gymnastics, Lacrosse (girls), Soccer, Softball, Cheerleading, Kickline)

Non-Contact Sports: Yes ____ No ____

(Cross Country, Swimming, Tennis, Track & Field, Weight Training, Volleyball)

Moderately Strenuous Sports: Yes ____ No ____

(Bowling, Golf)

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:

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