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).

HEALTH APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ No immunizations given today
❒ Immunizations given since last Health Appraisal:

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 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

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

PHYSICAL EXAM

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 (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ❒ None ❒ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

❒ **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.

❒ **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: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

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*

Since April 2003, HIPPA (Health Information Proliferation Privacy Act) requires your healthcare provider to have the completed form below to share Protected Medical Information with the school district. Schools are required to have signed parent release under FERPA (Federal Education 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 imp act 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_____

This authorization is valid for the entire academic school career K-12

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 redisclosure 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.

_____ _____

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

IF YOUR CHILD REQUIRES MEDICATION IN SCHOOL, PLEASE SIGN THE PERMISSION BELOW.
I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider.
Name_____Date_____