NYSED requires an annual physical exam for new entrants, students in Pre-K, K, 2, 4, 7, and 10, sports, working permits and triennially for the Committee on Special Education. This exam complies with NYSED requirements, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and school medical director. Revised 2/08

LONG BEACH PUBLIC SCHOOLS 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 (Medication orders are valid for the current school year)

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 3 day supply of 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, volleyball, cross-country, handball, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, 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: _____

Provider's Signature: _____ Date: _____ Phone: _____ (Provider's stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

NEW YORK STATE LAW REQUIRES A CERTIFICATE OF IMMUNIZATION BEFORE ADMITTANCE TO SCHOOL

DPT /DTaP	OPV/IPV	MMR	MUMPS	HIB/HBVC	HEPATITIS B
___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
___/___/___	___/___/___	**MEASLES**	**RUBELLA**	___/___/___	___/___/___
___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DT ___/___/___	___/___/___	___/___/___	___/___/___		
Td ___/___/___	**HEPATITIS A**	**HPV**	**Pneumococcal**	**VARICELLA (Vaccine)** ___/___/___	
Tdap ___/___/___	___/___/___	___/___/___	___/___/___	**VARICELLA (Vaccine)** ___/___/___	
	___/___/___	___/___/___	**Meningococcal**	**VARICELLA (Disease)** ___/___/___	
	___/___/___	___/___/___	___/___/___		

MANTOUX TEST	CHEST X-RAY	LEAD SCREENING	INFLUENZA VACCINE	OTHER VACCINE (Indicate)	OTHER TEST (Indicate)
___/___/___	___/___/___	___/___/___	___/___/___	_____	_____
RESULT	**RESULT**	**RESULT**		___/___/___	___/___/___
_____	_____	_____		**RESULT**	**RESULT**
				_____	_____

I certify that the aforementioned student has completed all required immunizations.
Doctor's Signature _____ Date: _____
I certify that the aforementioned student will have completed all immunizations by: _____
Doctor's Signature _____ Date: _____

****

Significant Medical/Surgical History _____

_____

_____

****

Additional findings on physical exam: **Date** _____ **Findings:** _____

_____

_____

_____

****

Additional Medications: (Medication orders are valid for the current school year)

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 3 day supply of medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

****

Additional Recommendations/ Referrals: _____

_____

_____

****

Provider's Signature: _____ Phone: _____ (Provider's stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____