

## LONG BEACH PUBLIC SCHOOLS HEALTH APPRAISAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

- |   |  |
|---|--|
| <input type="checkbox"/> Immunization record attached<br><input type="checkbox"/> No immunizations given today<br><input type="checkbox"/> Immunizations given since last Health Appraisal: | Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____<br>PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____<br>Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____<br>Dental Referral <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> 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	

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: \_\_\_\_\_