

**WEST IRONDEQUOIT CENTRAL SCHOOL DISTRICT**

**HEALTH APPRAISAL FORM**

Grade: \_\_\_\_\_ School: \_\_\_\_\_  
*NYSED requires an annual physical exam for new entrants, students in grades K, 2, 4, 7, & 10, sports, work permits and triennially for the Committee on Special Education.*

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**IMMUNIZATIONS/SCREENING**

Immunizations given since last Health Appraisal:  None given today  Immunization record attached

	1st	2nd	3rd	4th	5th
<b>Diphtheria</b>	*	*	*		
<b>Tetanus</b>	*	*	*		
<b>Polio (type)</b>	*	*	*	*if IPV	
<b>MMR</b>	*	*	*		
<b>Hep B</b>	*	*	*		
<b>Varicella</b>	*	<input type="checkbox"/> Disease			

<b>SICKLE CELL SCREEN</b>		Date:
Positive	Negative	
PPD		Date:
Positive	Negative	
<b>LEAD SCREEN</b>		Date:
Positive	Negative	

Vision - without glasses/contact lenses	R	L
Vision - with glasses/contact lenses	R	L
Vision - Near Point	R	L
Hearing	R	L

*\*-required for entry to school in NYS - requirements may vary by age and grade*

**1. Significant Medical/Surgical History:**  See attached

**2. Allergies**  Food  Insect  Seasonal  Medication  **LIFE THREATENING**

**PHYSICAL EXAM**

Check here if entire exam normal  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B.P.: \_\_\_\_\_  
 Normal Abnormal Comments

General appearance			
Nutrition/Body Mass Index			1-5:1=Cachectic (BMI<17.5), 3=WNL (BMI 18.5-24.9), 5=Obese (BMI>29.9)
Skin			
Head			
Eyes			
Ears			
Nose, Throat & Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen			
Genitalia			
Musculoskeletal			Tanner - I. II. III. IV. V.
Neurological			Scoliosis: Negative Positive

**4. Medication:** (list all):  None

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home:

I assess this student to be self directed and may self-carry medication  Yes  No  
 (School nurse to also assess self-direction.)

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

**Physically qualified for sports or full playground OR only as checked below:**

\_\_\_ Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water pol

\_\_\_ Limited contact: cheerleading, field, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softba

\_\_\_ Non-contact: badminton, bowling, golf, swimming, table tennis, tennis, archery, riflery, weight training, crew, dancing, track, running

\_\_\_ Knowledge based experience only.

**Physically qualified for employment OR specify accommodation:**

**Known or suspected disability:** \_\_\_\_\_  Please monitor

**Restrictions:** \_\_\_\_\_  Please monitor

**Protective equipment required:**  Athletic cup  Glasses/eyeware  Other: \_\_\_\_\_

*This exam complies with NYSED requirements above and is valid for one year through the last day of the month dated below, with the exception of any illness or injury lasting more than five days that will negate this certification.*

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_

**WEST IRONDEQUOIT CENTRAL SCHOOL DISTRICT**

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays. If your child requires medication in school, please sign the permission below.

**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) or Speech Therapist (ST):

The healthcare provider may disclose the following protected health information: (check all that apply)

- Immunizations
- Health Appraisals
- Past/current medical condition and its impact on attendance or school programming or need for therapy
- Other \_\_\_\_\_

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational programs
- To assess the impact 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 therapy purpose
- Other \_\_\_\_\_

Please select one:

- This authorization is valid for the entire academic school year 20\_\_\_\_-20\_\_\_\_
- This authorization shall expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ (MO/DD/YR)

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 re-disclosure 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.

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.

I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider.

Name \_\_\_\_\_ Date \_\_\_\_\_