NYSED requires an annual physical exam for new entrants, students in Grades Pre-K or K, 1, 3, 5, 7, 9, 11, 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

☐ Immunization record attached Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____

☐ No immunizations given today Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

☐ 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 ___

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):

☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th

☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ 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 1st dose	Date 2nd dose	Date 3rd dose	Date 1st booster	Date 2nd booster	Date 3rd 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:

Rev. 3/08

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