

Mohonasen Central Schools
Elementary Health Appraisal Form (Grades K-5)

*NYSED requires an annual physical exam for all new entrants; students in Grades K, 2, 4, 7, 10, and triennially for (CSE).
Any students not presenting the required physical will be examined by the school physician during the school year.*

Name: _____ Date of EXAM: _____
Gender: ☐ M ☐ F Date Of Birth: _____ Age: _____ Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunizations & date given since last Health Appraisal: _____
☐ Immunization record attached **Sickle Cell Screen:** ☐ Positive ☐ Negative ☐ Not done Date: _____
☐ No immunizations given today **PPD:** ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____

Dental Referral ☐ Yes ☐ No ☐ Date: _____ Providers Name _____

Significant Medical/Surgical History: ☐ See attached _____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
Other _____

Allergies: ☐ None ☐ LIFE THREATENING _____ ☐ Food _____
☐ Insect _____ ☐ Seasonal _____ ☐ Medication _____ ☐ Other _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____

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

Vision-Far R 20/____ L 20/____ With correction R 20/____ L 20/____
Vision-Near R 20/____ L 20/____ With correction R 20/____ L 20/____

Hearing ☐ Pass 20 db sc both ears or R _____ L _____ **Scoliosis:** ☐ Negative ☐ Positive: _____

☐ **EXAM ENTIRELY NORMAL** Tanner: I II III IV V ☐ **Referral** _____
Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form ☐ **Medication Orders for School Attached**

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

****Please advise parent to bring in additional medication(s) in the event morning dose not given or emergency sheltering in school is needed.**

PHYSICAL EDUCATION / PLAYGROUND / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, playground and school activities**
☐ **May participate only as checked below:**
☐ Limited contact: Gymnastics, volleyball, track & field, baseball, floor hockey, softball, soccer, football, basketball, playground, adventure activities.
☐ Non-contact: Bowling, swimming, dancing, running, walking, jump rope, calisthenics, plyometrics, scooter activity.
☐ **Specify medical accommodations needed for school:** _____ ☐ **None**
☐ **Known or suspected disability:** _____
☐ **Restrictions:** _____
☐ **Protective equipment required:** ☐ Glasses/sport eyewear ☐ Other: _____

Provider's Signature & Stamp: _____ **Date:** _____

Provider's Address & Phone Number: _____

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. 01/08