

**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 5<sup>th</sup>  
 5<sup>th</sup> through 49<sup>th</sup>  50<sup>th</sup> through 84<sup>th</sup>  85<sup>th</sup> through 94<sup>th</sup>  95<sup>th</sup> through 98<sup>th</sup>  99<sup>th</sup> 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: \_\_\_\_\_