

Amherst Christian Academy

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____
 School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal:

Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No 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: _____

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	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

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 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, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bow, golf, swim, table tennis, tennis, archery, riflery, 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: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

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

Amherst Christian Academy HEALTH INFORMATION RECORD

Student _____ Grade _____
(Last name) (First name)

PARENTS: Check the information that applies and add any pertinent information. *(Please return completed form by the 1st day of attendance)*

Accidents:

- Serious head injury _____
- Loss of consciousness _____
- Other *(specify):* _____

Eye Difficulties:

- "Lazy eye" _____
- Glasses or contact lens _____
- Prosthesis _____
- Other *(specify):* _____

Ear Problems:

- Ear Infections _____
- Tubes _____
- Hearing Loss _____
- Throat infections _____
- Other *(specify):* _____

Heart Problems:

- Heart murmurs _____
- Congenital heart disease _____
- Rapid heartbeat/palpitations _____
- Other *(specify):* _____

Respiratory Difficulties:

- Asthina _____
- Bronchitis/pneumonia _____
- Cystic fibrosis _____

Kidney/Bladder Difficulties:

- Kidney disease _____
- Bladder infection _____
- Enuresis *(bedwetting)* _____
- Encopresis *(fecal soiling)* _____
- Undescended *(or one)* testicle(s) _____

Special Educational Needs: _____

Does any close relative in your family have a history of: *(Check and indicate relationship to child.)*

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Birth Defect _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Sickle Cell Anemia _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Learning Problems _____ | <input type="checkbox"/> Mental Retardation _____ | <input type="checkbox"/> Other _____ | |

When did your child have a physical examination?

Purpose of examination: routine check-up Illness/Injury *(specify):* _____
Date Physician/Clinic

Have there been any changes or additions in the family the past year? *(For example, health problems, changes in marital status, changes in occupation, new brother or sister, etc.?)* Explain: _____

Parent /Guardian Signature: _____ **Date:** _____

Musculoskeletal/orthopedic problems:

- Joint pain or swelling _____
- Limitation of movement _____
- Fractures _____
- Braces/wheelchair/adaptive equipment _____
- Prosthesis _____
- Other *(specify):* _____

Poor Coordination *(specify):* _____

Birth Defects *(specify):* _____

Hospitalizations *(specify):* _____
 Operations *(specify):* _____

Illness with high fever *(greater than 103°):* _____
 Seizures _____
 Staring spells _____
 Tics _____

Allergies *(specify):* _____

Currently or regularly taking medication _____
Reason _____
Is medication required in school? _____

Skin Conditions *(specify):* _____

Chicken pox _____ Mono _____

Tuberculosis TB contact _____

Diabetes _____ Hepatitis _____

Thyroid disease _____

Speech defect *(specify):* _____

Emotional problems *(specify):* _____