

**ORCHARD PARK CENTRAL SCHOOL DISTRICT
HEALTH APPRAISAL FORM**

Rev. 10/02

Name _____ Grade _____ M Fe Date of Birth _____
 Address _____ Phone Number _____

Immunizations & Screening

<input type="checkbox"/> None given today					
	<input type="checkbox"/> Given since last exam				
	1 st	2 nd	3 rd	4 th	5 th
DTaP	*	*	*	*	*
Polio: <input type="checkbox"/> IPV <input type="checkbox"/> OPV	*	*	*	*	*4 IPV only
HIB					
Tetanus					
Hepatitis B	*	*	*		
MMR	*	*			
Varivax	*				
Pneumococcal					

<input type="checkbox"/> Record attached	
SICKLE CELL SCREEN	Date
<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
PPD	Date
<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
LEAD SCREEN	Date
<input type="checkbox"/> Positive <input type="checkbox"/> Negative	

<input type="checkbox"/> Disease	Vision: without <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses	R	L
	Vision: with <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses	R	L
	Vision: Near Point	R	L
	Hearing: <input type="checkbox"/> Screening <input type="checkbox"/> Audiogram	R	L
	Tympanogram	R	L

Hep B: Recombivax HB 10mcg 2 dose schedule; only for adolescents 11 through 15 years of age
 * Required for NYS school entry- varies by age and grade

Medical History

- 1) Significant medical/surgical history: _____
 2) Allergies: _____
 3) Medications taken regularly: _____

Physical Examination

Height: _____ Weight: _____ BP: _____ / _____ Resting Pulse: _____ Fe LMP: _____

	Normal	Abnormal	Comments
General Appearance			
Nutrition			1-5: 1=Cachetic 3=WNL 5=Obese
Skin			
Head			
Eyes			
Ears			
Nose/Throat			
Teeth			
Neck: Nodes/Thyroid			
Lungs			
Heart			
Abdomen			
Genitalia			Tanner Stage: <input type="checkbox"/> I. <input type="checkbox"/> II. <input type="checkbox"/> III. <input type="checkbox"/> IV. <input type="checkbox"/> V.
Musculoskeletal			
Scoliosis	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	
Neurological			

- 4) Medication: None Medication at home only Medication to be given at school:
 Name, route, dosage, frequency, time: _____
 If morning dose is missed at home: _____
 Student is designated 'self-directed- capable of self- administration of medication with adult supervision; may carry MDI
 [Self-directed: knows use and purpose of medication, route, dosage, and frequency of administration.] Yes No
 Parent Name (Print) _____ Parent Signature _____

- Physically qualified for participation in sports, full playground, and school activities as indicated below (or circle):
 Contact/Collision: baseball, basketball, diving, field hockey, football, ice hockey, jumping, lacrosse, martial arts, softball, soccer, wrestling
 Non-contact/strenuous: cheerleading, cross-country, field, gymnastics, handball, running, skiing, track & field, volleyball
 Non-strenuous: archery, badminton, bowling, golf, riflery, swimming, table tennis Knowledge based experience only
 Protective equipment: athletic cup chest pad glasses/eye wear helmet joint pads mouth guard wrist guards
 Physically qualified for employment Known or suspected disability: _____
 Restrictions _____

Provider Name (please print) _____ Phone Number _____

Provider Signature _____ Date of Exam _____ FAX Number _____

Address _____