

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

Rev. 10/02

Name \_\_\_\_\_ Grade \_\_\_\_\_  M  Fe Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**Immunizations & Screening**

None given today

Given since last exam

Record attached

	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
DTaP	*	*	*	*	*
Polio: DIPV OPV	*	*	*		*4 IPV only
HIB					
Tetanus					
Hepatitis B	*	*	*		
MMR	*	*			
Varivax	*				
Pneumococcal					

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	

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

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

**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=Cachectic 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 \_\_\_\_\_

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