New York State Education Department (NYSED) requires a completed physical exam for students in Grades K, 2, 4, 7 and 10, students new to the district, working permits and as requested for the Committee on Special Education (CSE). Please contact your child's physician to schedule an appointment for an examination. Once your physician has completed the attached form, please return it to your school nurse. Completion of a current physical examination is a state mandate for school attendance. Please contact your school nurse for any questions or concerns.

Lockport City School District 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

Date of Exam:

Height: _____ Weight: _____ Blood Pressure: _____ Heart rate: _____

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
BMI Chart on reverse side:				
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ 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: _____

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. Parents are advised to send in additional medication in the event that emergency sheltering is necessary at school.

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, bowl, 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: _____

(Stamp below)

Provider's Signature: _____ **Phone**: _____

Provider's Name/Address: _____ **Date**: _____

Parent Signature: _____ **Date**: _____

This exam complies with NYSED requirements and is valid for twelve months from the start of the school year, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider or the Director of School Health Services.
Rev. 10/3/07, 1/08, 4/2012 BS:bas