

LANCASTER CENTRAL 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: _____

Does this child have a history of concussion? Yes No If yes, give date(s) and details _____
 Does this child have a history of ? Chest Pain Heart Disease Lung Disease
 Is there a family history of sudden death from heart disease at a young age? Yes No If yes Please specify _____
 Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ 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 <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: none;">Vision - without glasses/contact lenses</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;">Referral</td> </tr> <tr> <td style="border: none;">Vision - with glasses/contact lenses</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Vision - Near Point</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> </table>	Vision - without glasses/contact lenses	R	L	Referral	Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
Vision - without glasses/contact lenses	R	L	Referral														
Vision - with glasses/contact lenses	R	L															
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
 **** I Attest that this student had demonstrated to me that they can self-administer the medications listed safely and effectively and my carry and use this medication independently at school/school sponsored activity with no supervision by school staff**
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: cheerleading, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowling, 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: _____

I give permission for medication to be administered to my child as ordered by my health care provider.
 Parent Signature: _____ Date: _____