Ballston Spa

Educating Everyone Takes Everyone

CENTRAL SCHOOL DISTRICT

Health Appraisal Form

The New York State Education Department 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). Please provide all of the information requested below.

STUDENT INFORMATION

Last Name	First Name	Date of Birth	Age	Gender

PROVIDER / PHYSICIAN INFORMATION

Provider/Physician Name	License / NPI #	Telephone

Street Address	City	State	Zip Code

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization Record Attached ☐ No Immunizations Given Today

☐ Immunizations Given Since Last Health Appraisal *(Please List)*: _____

_____

☐ **Sickle Cell Screen:**	☐ Positive	☐ Negative	☐ Not Done	Date
☐ **PPD:**	☐ Positive	☐ Negative	☐ Not Done	Date
☐ **Elevated Lead:**	☐ Positive	☐ Negative	☐ Not Done	Date
☐ **Dental Referral:**	☐ Positive	☐ Negative	☐ Not Done	Date

Significant Medical / Surgical History *Detail Below or Attach Descriptions*

_____

_____

Specific Current Diseases

☐ Asthma ☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension

☐ Other: _____

Allergies

☐ LIFE THREATENING ☐ Food _____ ☐ Insect _____

☐ Other: _____ ☐ Seasonal: _____

☐ Medication: _____

PHYSICAL EXAMINATION

Date of Examination ☐ Height ☐ Weight ☐ Blood Pressure ☐

Body Mass Index

Index: ☐ ☐ - ☐

Weight Status Category (BMI Percentile)

☐ Less than 5th ☐ 5th through 49th ☐ 50th through 84th

☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

Vision	Without Glasses/Contact Lenses	R 20 / ☐	L 20 / ☐	Referral ☐
	With Glasses/Contact Lenses	R 20 / ☐	L 20 / ☐	Referral ☐
	Near Point	R 20 / ☐	L 20 / ☐	Referral ☐

Hearing ☐ Pass (20 db sweep check both ears) OR R ☐ db L ☐ db Referral ☐

Tanner I ☐ II ☐ III ☐ IV ☐ V ☐ **Urinalysis** Glucose ☐ Protein ☐

Scoliosis ☐ Negative ☐ Positive _____

Specify any abnormality during health examination (attach detail if needed):

_____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE

☐ Free from contagions & physically qualified for all physical education, sports, playground, work and/or school activities OR only as checked:

☐ **Limited contact:** Cheerleading, Gymnastics, Ski, Volleyball, Cross-country, Handball, Baseball, Floor Hockey, Softball.

☐ **Non-contact:** Badminton, Bowling, Golf, Swimming, Table Tennis, Tennis, Archery, Weight Training, Dance, Track, Running, Walking, Rope Jumping.

☐ 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 Signature ☐ Date ☐

Parent Signature ☐ Date ☐

Place provider/ physician stamp here: