

**EAST SYRACUSE MINOA SCHOOLS
HEALTH APPRAISAL FORM ***

Name _____ Gr _____ Date of Exam _____

Date of Birth _____ Gender: Male Female

IMMUNIZATION / HEALTH HISTORY	
<input type="checkbox"/> Immunization record attached <input type="checkbox"/> No immunizations given today <input type="checkbox"/> Immunizations given since last Health Appraisal:	PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ Blood Lead Test _____ mcg/dL <input type="checkbox"/> Not done Date: _____ Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____

Specify current and chronic disease: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Single organ _____ Other _____

Allergies: **LIFE THREATENING** Food: _____ Insect: _____ Other _____
 Seasonal Medication: _____

PHYSICAL EXAMINATION											
Height: _____ Weight: _____	Blood pressure: _____ / _____	BP Re check: _____ / _____	Pulse: _____								
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		Vision and Hearing Screening <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">Vision- without / with glasses/contact lenses</th> <th style="width: 12.5%;">R 20/</th> <th style="width: 12.5%;">L 20/</th> <th style="width: 50%;">Referral</th> </tr> <tr> <td>Hearing</td> <td>R dB</td> <td>L dB</td> <td></td> </tr> </table>		Vision- without / with glasses/contact lenses	R 20/	L 20/	Referral	Hearing	R dB	L dB	
Vision- without / with glasses/contact lenses	R 20/	L 20/	Referral								
Hearing	R dB	L dB									

Eyes	<input type="checkbox"/> PERRLA <input type="checkbox"/> EOMI <input type="checkbox"/>	Neck	<input type="checkbox"/> No Thyromegaly <input type="checkbox"/>	Scoliosis	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Ears	<input type="checkbox"/> TM's NI landmarks <input type="checkbox"/> Not examined <input type="checkbox"/>	Heart	<input type="checkbox"/> w/o Murmur <input type="checkbox"/> Regular <input type="checkbox"/>	Extremities	<input type="checkbox"/> NI gait <input type="checkbox"/> Full ROM <input type="checkbox"/> No C/C/E <input type="checkbox"/>
Nose	<input type="checkbox"/> NI mucosa <input type="checkbox"/> w/o bleeding <input type="checkbox"/>	Lungs	<input type="checkbox"/> CTA <input type="checkbox"/>	Skin	<input type="checkbox"/> w/o suspicious lesions <input type="checkbox"/> Acne <input type="checkbox"/>
Teeth	<input type="checkbox"/> w/o caries <input type="checkbox"/> Good Repair <input type="checkbox"/>	Abdomen	<input type="checkbox"/> w/o Guard <input type="checkbox"/> w/o Mass, Benign <input type="checkbox"/>	Maturation (if applicable)	<input type="checkbox"/> Age of Menarche _____ <input type="checkbox"/> Tanner Stage-I II III IV V
Tonsils	<input type="checkbox"/> w/o exudates <input type="checkbox"/> w/o redness <input type="checkbox"/>	Hernia	<input type="checkbox"/> None <input type="checkbox"/> Not examined <input type="checkbox"/>	Other	
Lymph	<input type="checkbox"/> w/o LA <input type="checkbox"/> Not Examined <input type="checkbox"/>	Genitalia	<input type="checkbox"/> Normal <input type="checkbox"/> N/A <input type="checkbox"/> N/A - USPSTF*		

MEDICATION INFORMATION

List all NEW medications and the dosages for this student (This is NOT an order for medication use in school.):

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

PHYSICAL EDUCATION: Full Physical Activity Modified Physical Activity _____

Physically qualified for all interscholastic sports, intramural and extramural activities and full playground activities OR only as checked below:

- Contact / Collisions:** Basketball, Diving, Football, Hockey, Lacrosse, Martial Arts, Soccer, Wrestling
- Limited Contact:** Baseball, Bicycling, Cheerleading, Field (High Jump and Pole Vault), Floor Hockey, Gymnastics, Handball, Horseback Riding, Racquetball, Skating, Skiing, Softball, Squash, Ultimate Frisbee, Volleyball.
- Non-contact:** Archery, Badminton, Body Building, Canoeing, Cross Country, Dancing, Field (Discus, Javelin, Shot Put), Golf, Rope Jumping, Running, Scuba Diving, Strength Training, Swimming, Table Tennis, Track, Walking, Weight Lifting.

WORKING Physically qualified for lawful employment.

PAPERS: Physically qualified for limited employment due to a disability. Specify accommodation _____

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: _____ Fax: _____

*The USPSTF publishes guidelines for complete physical exams. These are the best evidence available and can be obtained from www.ahrq.gov/clinic/upstf.html