EAST SYRACUSE MINOA SCHOOLS
HEALTH APPRAISAL FORM *

Name _____ Gr _____ Date of Exam _____

Date of Birth _____ Gender: ☐ Male ☐ Female

IMMUNIZATION / HEALTH HISTORY

- ❑ Immunization record attached
- ❑ No immunizations given today
- ❑ Immunizations given since last Health Appraisal:

PPD: ☐ Positive ☐ Negative ☐ Not done Date:_____

Blood Lead Test _____ mcg/dL ☐ Not done Date:_____

Dental Referral: ☐ Yes ☐ No ☐ 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):

❑ less than 5th ❑ 5th through 49th

❑ 50th through 84th ❑ 85th through 94th

❑ 95th through 98th ❑ 99th and higher

Vision and Hearing Screening			Referral
Vision- without / with glasses/contact lenses	R 20/	L 20/	
Hearing	R dB	L dB	

Eyes	❑ PERRLA ❑ EOMI ❑	**Neck**	❑ No Thyromegaly ❑	**Scoliosis**	❑ Positive ❑ Negative ❑
Ears	❑ TM's Nl landmarks ❑ Not examined ❑	**Heart**	❑ w/o Murmur ❑ Regular ❑	**Extremities**	❑ Nl gait ❑ Full ROM ❑ No C/C/E ❑
Nose	❑ Nl mucosa ❑ w/o bleeding ❑	**Lungs**	❑ CTA ❑	**Skin**	❑ w/o suspicious lesions ❑ Acne ❑
Teeth	❑ w/o caries ❑ Good Repair ❑	**Abdomen**	❑ w/o Guard ❑ w/o Mass, Benign ❑	**Maturation (if applicable)**	❑ Age of Menarche _____ ❑ Tanner Stage-I II III IV V
Tonsils	❑ w/o exudates ❑ w/o redness ❑	**Hernia**	❑ None ❑ Not examined ❑	**Other**	
Lymph	❑ w/o LA ❑ Not Examined ❑	**Genitalia**	❑ Normal ❑ N/A ❑ 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 PAPERS: ☐ Physically qualified for lawful employment.

☐ 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/upstfix.html