

NYSED 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).

KEENE CENTRAL SCHOOL

33 Market St., P.O. Box 67, Keene Valley, NY 12943 (518) 576-4555 Fax (518) 576-4599
www.keenecentralschool.org

HEALTH APPRAISAL FORM

Name: _____ Date of Birth: _____

Address: _____ Gender: M F Age: _____ Grade: _____ Phone: _____

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

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 border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Vision - without glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td style="text-align: center;">Referral</td> </tr> <tr> <td style="text-align: center;">Vision - with glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Vision - Near Point</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></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	
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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): _____

	Normal	Abnormal		Normal	Abnormal
General Appearance			Lungs		
Nutrition			Heart		
Skin			Abdomen		
Head			Genitalia		
Eyes			Musculoskeletal		
Nose, Throat, Teeth			Neurological		
Lymph Nodes/Thyroid			Ears		

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

Rev. 10/3/07

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- Medications to be taken at school need to be accompanied by a medication form filled out by the physician and parents.

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: _____ Fax: _____

Parent Signature: _____ Date: _____

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FOR PHYSICIAN USE ONLY

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year 20__ to 20__.

Any unmarked categories indicates disqualification from the particular group of sports activities.

CONTACT/COLLISION	LIMITED CONTACT/ IMPACT	STRENUOUS NONCONTACT	NONSTRENUOUS NONCONTACT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Field Hockey Football Ice Hockey Lacrosse Soccer Wrestling	Baseball Basketball Diving Gymnastics Handball Skiing-Cross Country Skiing-Downhill Softball Volleyball	Crew Cross-country Track and Field Swimming Tennis	Archery Bowling Golf Riflery

Physician's Signature

Date