Sherburne - Earlville Middle / High School

HEALTH APPRAISAL FORM

Fax: 607-674-7383

Name_____ ***Date of Birth** _____ ***Gender** ❑M ❑F ***Grade**_____

ALLERGIES: ❑***Medication*** _____

❑**Life threatening:** ❑Food _____ ❑Insect _____ ❑ Seasonal____ ❑ Latex _____ ❑ Other _____

Hx of Anaphylaxis: _____ Symptoms: _____ *Treatment:* ❒None ❒ Antihistamine ❒**Epinephrine Autoinjector**

Current Medications: _____

Immunizations given today: _____ ***PPD** (date placed)* _____ *Neg/Pos Lead screen?*_____

Significant Medical/Surgical History _____**Seizure hx?** _____

Height* _____ **Weight* _____ **Blood Pressure* _____*Pulse* _____*Respirations*_____ **History of chicken pox disease date_____

Vision: *Right* _____ *Left* _____ *(with/without lenses) Near Rt*_____*LT*_____ *Color perception*____ *Vision Referral?* _____

Hearing: *Right* _____ *Left* _____ *Hearing Referral?* _____ **Dental** *Referral?* _____ *Sickle Cell Screen?* _____

	Normal	*Abnormal*	*Explanation*
Scoliosis			*Degree of deviation?*
Eyes			
Ears			
Nose			
Throat			
Thyroid			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Genitals			*Tanner Scale:*
Extremities			
Nervous System			
Skin			
Nutrition			
Musculature			

Required

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

Specify current diseases: ***Required***

(check all that apply)

❑**Asthma -** ❑**Intermittent** ❑**Persistent**
❑*Rescue Inhaler* ❑ *Action Plan*

❑ **Diabetes, Type 1** ❑ **Diabetes, Type 2** ❑

❑ **Hyperlipidemia** ❑ **Hypertension**

❑ *Other* _____

Physical Assessment (to be performed by Health Care Professional)

❒ ***Protective equipment required:** ❒ Athletic Cup ❒ Sport/safety goggles ❒Medical/Brace/orthotic/hearing aides/prosthetic device ❒Insulin pump ❒Other: _____

❒ ***NO Contact/Collision sports:** Basketball, Baseball, Cheerleading, Diving, Field Events, Field Hockey, Football, Ice Hockey, Softball, Soccer, Volleyball, Weight Lifting, Wrestling

❒ ***NO Non-Contact sports:** Cross Country, Swimming, Tennis, Badminton, Track, Bowling, Golf

❒ **The above named student is physically qualified to participate in all physical education, sports, work, and school activities *for 1(one) year from date of exam.***

I request that my child be assisted in taking the medication(s) described below at school by the authorized person(s).
The medication is to be furnished in a properly labeled original container from the pharmacy.

Medication	*Diagnosis*	*Dose*	*Route*	*Time*	*Self Directed*	*Self Admin/Self carry*

_____ _____ _____

******Parent Signature*** ***Date*** ***Phone***

❒***I attest that this student has demonstrated to me that they can self-administer the medication(s) listed above safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school-sponsored activity with no supervision by school staff.***

_____ _____ _____

******Health Care Provider's Signature*** ****Date of Exam*** ***Phone/Fax***

**This information is required for sports participation and/or the New York State Department of Health* *(Rev.2/16)*