# Cincinnatus Central School District

2809 Cincinnatus Road ~ Cincinnatus, NY 13040
Phone (607) 863-3200 ~ Fax (607) 863-3094 ~Health Office

## HEALTH APPRAISAL

Student Name _____ Date of Birth _____

Address _____ Phone _____

## IMMUNIZATIONS/SCREENING

____ Immunizations given since last Health Appraisal: ____ None given today ____ Immunization record attached

| | 1st | 2nd | 3rd | 4th | 5th |
|---|---|---|---|---|---|
| DTaP | * | * | * | | |
| dT | * | * | * | | |
| OPV/IPV/eIPV | * | * | * | ** | |
| HIB | * | * | | | |
| Hep B | * | * | * | | |
| Varicella | * | Disease | | | |
| MMR | | | | | |
| Other | | | | | |

PLEASE PROVIDE MO/D/YR FOR ALL; *Required for entry to school in NYS: requirements may vary by age and grade; **if IPV

| SICKLE CELL SCREEN | | Date |
|---|---|---|
| Positive | Negative | |
| **PPD** | | Date |
| Positive | Negative | |
| **BLOOD LEAD TEST** | | Date |
| mcg/dL | | |

| | | |
|---|---|---|
| Vision-without glass/contact lenses | R | L |
| Vision-with glasses/contact lenses | R | L |
| Vision-Near Point | R | L |
| Hearing | R | L |

**Significant Medical/Surgical History** ____ see attached _____

**Allergies**: _____ None _____ Food _____ Insect _____ Seasonal _____ Medication _____ **LIFE THREATENING** _____

## PHYSICAL EXAM

_____ Check here if entire exam normal Height _____ Weight _____ B.P. _____

| | Normal | Abnormal | Comments |
|---|---|---|---|
| General Appearance | | | |
| Nutrition/Body Mass Index | | BMI = / % | |
| Skin | | | |
| Head | | | |
| Eyes | | | |
| Ears | | | |
| Nose, Throat, Teeth | | | |
| Lymph Nodes/Thyroid | | | |
| Lungs | | | |
| Heart | | | |
| Abdomen | | | |
| Genitalia | | | Tanner – I. II. III. IV. V. |
| Musculoskeletal | | | Scoliosis / Negative / Positive |
| Neurological | | | |

**Medication** (list all) _____ None

Name _____ Dosage/Time _____

Name _____ Dosage/Time _____

If AM dose is missed at home _____

I assess this student to be self directed and may self-carry medication _____ No _____ Yes (School nurse to also assess self-direction)

Please send in additional medication in the event that emergency sheltering is necessary at school.

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

_____ Physically qualified for sports or full playground OR only as checked below:
_____ Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water polo
_____ Limited contact: cheerleading, field, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softball
_____ Non-contact: badminton, bowl, golf, swim, table tennis, archery, riflery, weights, crew, dance, track, running, walking, jump rope
_____ Knowledge based experience only
_____ Physically qualified for employment OR specify accommodation _____
_____ Known or suspected disability _____ _____ Please monitor
_____ Restrictions _____ _____ Please monitor
_____ Protective equipment required _____ Athletic cup _____ Glasses/sport eyewear _____ Other _____

NYS Education Department requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7, & 10, sports, working permits, and, triennially, for the Committee on Special Education (CSE). This exam complies with NYSED requirements above and is valid for one year through the last day of the month dated below with the exception of any illness or injury lasting more than five days that will negate this exam.

**PROVIDER'S SIGNATURE** _____ Date _____

**PROVIDER'S NAME** _____ Phone _____ FAX _____

**PROVIDER'S ADDRESS** _____

I give permission for medication to be administered to my child as ordered by my health care provider.

**PARENT/GUARDIAN SIGNATURE** _____ Date _____