LONG BEACH PUBLIC SCHOOLS HEALTH APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

School: ______________________ **Gender:** ❑ **M** ❑ **F** **Grade:** ______________________

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: ____________

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Significant Medical/Surgical History: ❒ See attached ______________________

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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: ____ ____ . ____	Vision - without glasses/contact lenses	R	L	*Referral*
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ 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): ______________________

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MEDICATIONS

Medications (list all): ❒ None ❒ Additional medications listed on reverse of form (Medication orders are valid for the current school year)

Name: ______________________ Dosage/Time: ______________________

Name: ______________________ Dosage/Time: ______________________

If AM dose is missed at home: ______________________

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional 3 day supply of medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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, volleyball, cross-country, handball, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, 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: __________

Provider's Signature: ______________Date:________Phone:______________ (Provider's stamp below)

Provider's Name/Address: ______________________ Fax: ______________

Parent Signature: ______________________ Date: ______________

NYSED requires an annual physical exam for new entrants, students in Pre-K, K, 2, 4, 7, and 10, sports, working permits and triennially for the Committee on Special Education. This exam complies with NYSED requirements, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and school medical director. Revised 11/11

NEW YORK STATE LAW REQUIRES A CERTIFICATE OF IMMUNIZATION BEFORE ADMITTANCE TO SCHOOL

	DPT /DTaP	OPV/IPV	MMR	MUMPS	HIB/HBVC	HEPATITIS B
	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
	____/____/____	____/____/____	MEASLES	RUBELLA	____/____/____	____/____/____
	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
DT	____/____/____	HEPATITIS A	HPV	PCV 7	PCV 13	VARICELLA(Vaccine)
Td	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Tdap	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
		____/____/____	____/____/____	____/____/____	____/____/____	VARICELLA(Disease)
	MENINGOCCOCAL			____/____/____	____/____/____	____/____/____
	_____/_____/_____					

MANTOUX TEST	CHEST X-RAY	LEAD SCREENING	INFLUENZA VACCINE	OTHER VACCINE (Indicate)	OTHER TEST (Indicate)
				__________________	____________________
____/____/____	____/____/____	____/____/____	____/____/____	_____/_____/_____	______/______/______
RESULT	RESULT	RESULT	____/____/____		RESULT
_______________	________________	_______________			

I certify that the aforementioned student has completed all required immunizations.
Doctor's Signature ____________________________________Date: __________________
I certify that the aforementioned student will have completed all immunizations by: __________
Doctor's Signature ____________________________________Date: __________________

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Significant Medical/Surgical History____

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Additional findings on physical exam: Date:____________ Findings:_______________________

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Additional Medications: (Medication orders are valid for the current school year)

Name: ____ Dosage/Time: ______________________________________

Name: ____ Dosage/Time: ______________________________________

If AM dose is missed at home: ____

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional 3 day supply of medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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Additional Recommendations/ Referrals: ____

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Provider's Signature: ____________________________________ Phone: ____________________(Provider's stamp below)

Provider's Name/Address: ________________________________ Fax: ______________________

Parent Signature: _______________________________________ Date: ______________________