

## 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: \_\_\_\_\_

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 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	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	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis:  Negative  Positive: \_\_\_\_\_

Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

### MEDICATIONS

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

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 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, 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: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)

Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Gender:  Male  Female

**Student Health Body-Mass-Index and Weight Status Category Reporting Form**

This form should be completed and attached to student health certificates for students in Kindergarten, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup> or 10<sup>th</sup> grade. This information is required under New York State Education Law by the beginning of the 2008 academic school year.

Date of Measurement: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm dd yy

Grade:  K  2  4  7  10

Body Mass Index (BMI): \_\_\_\_\_

**Weight Status Category (sex-specific BMI-for-age percentile):**

- < 5<sup>th</sup>
- 5<sup>th</sup> to <50<sup>th</sup>
- 50<sup>th</sup> to <85<sup>th</sup>
- 85<sup>th</sup> to <95<sup>th</sup>
- 95<sup>th</sup> and over

**Primary Race/Ethnicity:**

- Black (not Hispanic)
- White (not Hispanic)
- Hispanic
- Asian
- Other

**In the last twelve months, has the student had:**

- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| Prediabetes     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Type 1 diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Type 2 diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prehypertension | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Provider Name: \_\_\_\_\_

or stamp here

# NEW YORK STATE IMMUNIZATION REQUIREMENTS FOR SCHOOL ENTRANCE SCHOOL K – 12

Diphtheria Toxoid Containing Vaccine..... (DTP, DTaP)	3 doses
Polio..... (OPV, IPV)	3 OPV or 4 IPV; 4 doses if combination of the two types
Measles, Mumps, Rubella..... (MMR)	Born before 1985, 1 dose Born on or after 1985, 2 doses of measles and 1 dose each of mumps and rubella
Hepatitis B.....	Born on or after 01/01/93 – 3 doses 7 <sup>th</sup> graders entering school on or after 09/01/2000
***Hep B – 7 <sup>th</sup> graders – 3 doses of Recombivax HB, Energix B or 2 doses of adult hepatitis B vaccine (Recombivax) for children 11 – 15 years old	
Hib.....	Not applicable
Varicella.....	1 dose if under age 13 and 2 doses if 13-18 years of age (see new amendment requirements)

I understand that if my child transfers from a school district within New York State that I have two weeks from the date of admission or 30 days if transferred from outside New York State, to produce an official record of my child's immunization or in lieu of this either of the following:

- a) A written statement subscribed and affirmed as true by a parent or guardian of the child that the parent or guardian is a bona fide member of a specified recognized religious organization whose teachings are contrary to the administration of immunizing agents.
- b) New York State licensed physician's certificate stating that the listed immunizations are detrimental to the child's health. This MUST specify which vaccine is detrimental and the length of time for the exemption.

I have been informed of the immunization requirements for admission to schools in New York State as required by the N.Y. S. Public Law, Section 2164.

I further understand that, under the law, if the school **DOES NOT** receive the evidence of immunization within the specified period, my child **WILL BE EXCLUDED** from school until such time as the evidence is received.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

**SETON CATHOLIC CENTRAL  
MEDICAL HISTORY EVALUATION**

STUDENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SPORT: \_\_\_\_\_

LEVEL: \_\_\_\_\_

(Varsity, JV, Modified)

HOME PHONE: \_\_\_\_\_

GRADE: \_\_\_\_\_

**DEAR PARENT:**

**Please check any of the following conditions which apply to your child.**

\_\_\_ Absence of function in one eye  
(Right or Left) \_\_\_\_\_

\_\_\_ Loss of hearing in one/both ears  
(Right or Left) \_\_\_\_\_

\_\_\_ Head Injury \_\_\_\_\_

\_\_\_ Concussion \_\_\_\_\_

\_\_\_ Convulsion, seizure, epilepsy \_\_\_\_\_

Medical Evaluation of the Heart

\_\_\_ When exercising has your child  
experienced chest pain?

\_\_\_ When exercising has your child  
experienced palpitations?

\_\_\_ When exercising has your child  
had an episode of fainting?

\_\_\_ Unexplained death of a family  
member at an age less than 40?

\_\_\_ Spleen or Liver Condition  
(i.e Hepatitis) \_\_\_\_\_

\_\_\_ Hernia \_\_\_\_\_

\_\_\_ Absence or disease of kidney  
(Right or Left) \_\_\_\_\_

\_\_\_ Absence of or undescended  
testicle \_\_\_\_\_

Chronic recurrent illness \_\_\_\_\_

Heat exhaustion or stroke \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Surgery: \_\_\_\_\_

When? \_\_\_\_\_

For What? \_\_\_\_\_

Allergies: Foods (s) \_\_\_\_\_

Hay Fever \_\_\_\_\_

Drugs (s) \_\_\_\_\_

Bee Sting \_\_\_\_\_

Asthma \_\_\_\_\_

Diabetes \_\_\_\_\_

Damage to knee cartilage \_\_\_\_\_

(Right or Left) \_\_\_\_\_

Repeated sprains or strains \_\_\_\_\_

Back Problem \_\_\_\_\_

Fracture (s) \_\_\_\_\_

\* Is your son or daughter taking any medicine on a regular basis?

If yes, for what? \_\_\_\_\_

\*Tetanus booster in the last 10 years? \_\_\_\_\_

Signed \_\_\_\_\_

(Parent or Guardian)

**\*\* SETON CATHOLIC WILL NOT ASSUME ANY RESPONSIBILITY FOR LOSS  
OR REPLACEMENT OF GLASSES OR LENSES.**