

WYANDANCH SCHOOL DISTRICT

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).

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: _____ Referral

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 99 th <input type="checkbox"/> 99 th and higher	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: _____ (Stamp below)

Provider's Signature: _____ Phone: _____
 Provider's Name/Address: _____ Fax: _____
 Parent Signature: _____ Date: _____

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

WYANDANCH UNION FREE SCHOOL DISTRICT
 OFFICE OF CENTRAL REGISTRATION & ATTENDANCE
 54 SOUTH 32ND STREET
 WYANDANCH, NY 11798

STUDENT: _____
 DATE: _____

SCHOOL: _____
 GRADE: _____

Dear Parent/Guardian,

New York State Immunization Law requires children enrolling in school for the first time or are new to the Wyandanch Schools, must have a certificate from his/her physician for the following immunizations. Month, day and year must be indicated.

1. Polio (OPV) #1 _____ #2 _____ #3 _____ #4 _____
 Polio (IPV) #1 _____ #2 _____ #3 _____ #4 _____

2. DTAP #1 _____ #2 _____ #3 _____ #4 _____

TD Booster (adult type) _____

Tdap #1 _____ required for students entering 6th grade and who are 11 yrs of age or older

** 3. Measles Vaccine #1 _____ #2 _____
 Mumps Vaccine (M-M-R) #1 _____ #2 _____
 Rubella

** 4. Measles Vaccine #1 _____ #2 _____
 OR - ↓

5. Mumps Vaccine #1 _____ #2 _____

6. Rubella Vaccine #1 _____ #2 _____

7. _____ Titer Date done _____ Results _____

* 8. Haemophilus Influenzae (Type B) (Hib) #1 _____ #2 _____ #3 _____ #4 _____

9. Tuberculosis Test Type _____ Date _____ Results _____

10. Lead Level Screening (strongly recommended) Date _____ Results _____ MCG (Pre-K or K)
 DL

11. Hepatitis B #1 _____ #2 _____ #3 _____

12. Varicella (chicken pox) _____ Is required for Pre-K & K born on or after 1/1/98
 All students entering 6,7,8th grade in Sept born on or after 1/1/94

ase Note: **For children 18 months to 5 years in Day Care or any Pre-School Program.
 *REQUIRED BY THE WYANDANCH SCHOOL DISTRICT

Physician's Signature _____ Physician's Address _____ Physician's Telephone _____	PHYSICIAN'S STAMP
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WYANDANCH SCHOOL DISTRICT
54 SOUTH 32ND STREET
WYANDANCH, NY 11798

HEALTH INFORMATION FORM

Child's Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Place of Birth: _____

Birth Weight: _____

Full Term or Premature: _____

Type of Delivery: _____

Father's Name: _____

Business Phone: _____

Mother's Name: _____

Business Phone: _____

Local physician to be called in case of emergency and parent cannot be reached:

Name of Doctor: _____

Phone: _____

Has child had any of the following? Please state dates.

Chicken Pox _____

Diabetes _____

Serious injuries _____

Measles _____

Pneumonia _____

Tonsillectomy _____

German Measles _____

Rheumatic Fever _____

Surgery _____

Roseola _____

Heart Disease _____

Mumps _____

Poliomyelitis _____

Allergies _____

Scarlet Fever _____

Tuberculosis _____

Asthma _____

Scarlatina _____

Epilepsy _____

Whooping Cough _____

Bar conditions _____

Hepatitis B _____

Does your child have any eye difficulties? If so, describe:

Name of specialist treating eye condition: _____

Does your child have any speech problems, (lisp, baby talk, etc.) If so, describe:

Is there any history in mother or father's family of Diabetes, Epilepsy, Heart Disease or Tuberculosis? If so, name relationship and diagnosis:

Please state the approximate age of your child when he/she sat up, _____, walked, _____, talked, _____.

Please list other children in family and their birth dates:

Parent Signature

Date