

Health Appraisal/Routine Physicals**Physician – Please use black ink and fill in completely**

Student's name: _____

KENMORE-TOWN OF TONAWANDA UFSD

Department of Physical Education/Recreation/Athletics and Health Services

Grade _____ ☐ M ☐ F Date of birth _____

Address _____ Telephone _____

IMMUNIZATIONS / SCREENINGS(Check one and record below) ☐ No immunizations/screenings given today ☐ Given since last exam ☐ Record attached

(Fill in dates)	1st	2nd	3rd	4th	
DTaP	*	*	*		
Polio <input type="checkbox"/> IPV <input type="checkbox"/> OPV	*	*	*		
HIB					
<input type="checkbox"/> Tetanus or <input type="checkbox"/> Tdap					
Hepatitis B**	*	*	*		
MMR	*	*			
Varivax	*				
Pneumococcal					

*Required for NYS school entry – varies by age and grade

** ☐ Hep B: Recombivax HB 10 mcg 2-dose schedule (only for adolescents 11 – 15 yrs of age)

Sickle Cell Screen	Positive	Negative	Date
PPD	Positive	Negative	Date
Lead Screen	Positive	Negative	Date
Vision/Hearing			
Vision without:	<input type="checkbox"/> glasses	<input type="checkbox"/> Contact lenses	R L
Vision with	<input type="checkbox"/> glasses	<input type="checkbox"/> Contact lenses	R L
Vision	Near point		R L
Hearing	<input type="checkbox"/> Screening	<input type="checkbox"/> Audiogram	R L
	Tympanogram		R L

MEDICAL HISTORY

Significant medical/surgical history: _____

Allergies: _____

Medications taken regularly: _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ B/P _____ / _____ Resting Pulse: _____ Fe LMP _____

	Normal	Abnormal
General appearance		
Nutrition		
Skin		
Head		
Eyes		
Ears		
Nose/Throat		
Teeth		

	Normal	Abnormal
Neck: nodes/thyroid		
Lungs		
Heart		
Abdomen		
Genitalia		
Musculoskeletal		
Scoliosis	<input type="checkbox"/> Neg	<input type="checkbox"/> Pos
Neurological		

Body Mass Index _____
Weight Status Category (BMI Percentile):
<input type="checkbox"/> less than 5th
<input type="checkbox"/> 5 th through 49th
<input type="checkbox"/> 50 th through 84th
<input type="checkbox"/> 85 th through 94th
<input type="checkbox"/> 95 th through 98th
<input type="checkbox"/> 99 th and higher

☐ No Medication ☐ Medication at home only ☐ Medication to be given at school

Name, route, dosage, frequency, time: _____

If morning dose is missed at home: _____

Missing organs: Eye, Kidney, Testicle

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

U/A results: _____

Student is 'self-directed' ☐ Yes ☐ No**Self-directed:** Student knows use and purpose of medication, route, dosage, and frequency of administration. Student is capable of Self-administration of medication with adult supervision; may carry MDI.

Parent/Guardian name (print) _____ Parent/Guardian signature: _____

SPORTS: Student is physically qualified for participation in sports, full playground, and school activities as indicated below:☐ **Contact/Collision:** Baseball, Basketball, Diving, Field hockey, Football, Ice hockey, Jumping, Lacrosse, Martial arts, Soccer, Softball, Wrestling☐ **Non-Contact/Strenuous:** Cheerleading, Cross-country, Gymnastics, Handball, Running, Skiing, Track and field, Volleyball☐ **Non-Strenuous:** Archery, Badminton, Bowling, Golf, Rifle, Swimming, Table Tennis☐ **Knowledge-based experience only****Protective equipment:** ☐ Athletic cup ☐ Chest pad ☐ Glasses/eyewear ☐ Helmet ☐ Joint pads ☐ Mouth guard ☐ Wrist guards**EMPLOYMENT:** ☐ Student is physically qualified for employment ☐ Known or suspected disability: _____☐ Restrictions _____

Provider name (please print) _____ Telephone # _____ Fax # _____

Provider signature _____ Date of exam _____

(1/08) 2.1d reverse