Health Appraisal/Routine Physicals

Physician – Please use black ink and fill in completely

KENMORE-TOWN OF TONAWANDA SCHOOL DISTRICT

Health Services

Student's name ________________________ 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 ☐ IPV ☐OPV	*	*	*		
HIB					
☐Tetanus or ☐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:	☐ glasses	☐Contact lenses	R L
Vision with	☐glasses	☐Contact lenses	R L
Vision	Near point		R L
Hearing	☐ Screening	☐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	☐ Neg	☐ Pos
Neurological		

Body Mass Index ___ ___ . ____

Weight Status Category (BMI Percentile):

Missing organs: Eye, Kidney, Testicle

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

U/A results: __________

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

Name, route, dosage, frequency, time: ________________________

If morning dose is missed at home: ________________________

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, Riflery, 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 ____________

Confidential/Health History

KENMORE-TOWN OF TONAWANDA UFSD

Health Services

This side to be completed by Parent/Guardian – Fill in completely and sign below.

ıdent's name ______________________________ ☐ Male ☐ Female
LAST FIRST MIDDLE

Home Address ______________________________ Telephone Number: __________

School ______________________________ Grade ________ Date of Birth ________

Has the child ever attended Ken-Ton Schools before? ☐ Yes ☐ No If Yes, when? __________

Has the child attended a New York State School Before? ☐ Yes ☐ No

Name and address of last school attended ______________________________

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Physician ______________________________ Telephone Number __________

Address ______________________________

Please indicate whether your child has ever experienced any of the following – Give dates and descriptions where necessary.

	Date		Date		Dates and Description
Chicken Pox		Diabetes		Accidents/Serious injury	
Measles(regular)		Mononucleosis		Allergy/Asthma	
Rubella (3-day)		Pneumonia		Fractures/Orthopedic Problems	
Mumps		Rheumatic Fever		Operations/Hospitalization	
Scarlet Fever		Tuberculosis		Irremedial Defect	
˜trep Throat				Seizure Disorder	

.ner ______________________________

Does this child wear glasses? ☐ Yes ☐ No for How long? How long have present glasses been worn?

Glasses prescribed by: Frequency of use (check one) ☐ Constant ☐ Reading only ☐ Distance only

Does this child have a hearing problem? ☐ Yes ☐ No (If yes describe)

Other ear conditions or tubes? (Describe)

Has this child in the past, or is this child now attending a clinic for any health reason? ☐ Yes ☐ No

Name of Clinic:

Is there any mental, emotional or physical condition the school should know about? (Describe)

Is this child currently on any medication? ☐ Yes ☐ No name of medication and dosage:

Reason for medication:

Signature of Parent/Guardian: ______________________________ Date: __________