MD HEALTH APPRAISAL FORM

Name: ______________________ Date of Birth ______________________

Address: ____ Phone: _________

IMMUNIZATIONS/SCREENING

___ Immunizations given since last Health Appraisal ___ None given today ___ Immunization record attached

***-required for entry to school in NYS – requirements may vary by age & grade**

	1st	2nd	3rd	4th	5th
DTaP	>	*	*		
Polio:type	>	*	*	*if IPV	
HIB					
Latest tetanus					
Hep B	*	*	*		
MMR	*	*			
Varivax	>	-Disease			
Pneumococcal					

SICKLE CELL SCREEN		Date:
Positive	Negative	
PPD		Date:
Positive	Negative	
LEAD SCREEN		Date:
Positive	Negative	

	R	L
Vision – without glasses/contact lenses	R	L
Vision-with glasses/contact lenses	R	L
Vision-Near Point	R	L
Hearing	R	L

1. **Significant Medical /Surgical History:** ______________________________

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2. Allergies: ______________________________

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3. Medication taken regularly: ______________________________

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PHYSICAL EXAM

Height: ___________ Weight: ___________ B.P. ___________ Resting Pulse: ___________

___ Check here if entire exam normal

	Normal	Abnormal	Comments
General appearance			
Nutrition			1-5 1=Cachectic, 3=WNL, 5=Obese
Skin			
Head			
Eyes			
Nose, Throat, Teeth			
Lymph Nodes			
Lungs			
Heart			
Abdomen			
Genitalia			Tanner – I. II. III. IV. V.
Musuloskeletal			Scoliosis: Negative Positive
Neurological			

4. Medication: ___ None ___ Medication at home only ___ Medication to be given at school

Name: ______________________________

Dosage/Time: ______________________________

If AM Dose is missed at home: ______________________________

PHYSICAL EDUCATION/SPORTS/PLAYGROUND

___ **Physically qualified for sports or full playground as indicated below.**

___ Contact/Collision: Basketball, Soccer, Jumping

___ Non-contact/strenuous: Cheerleading, Gymnastics, Volleyball, Running

___ Non-strenuous: Badminton, Golf, Table Tennis, Tennis

___ **Known or suspected disability**: ______________________________

___ **Restrictions** ______________________________

Provider's Signature ______________________ Date of PE: ___________

Providers Name: ______________________ Date: ___________

Provider's address ______________________ Phone: ___________