

BALLSTON SPA CENTRAL SCHOOL DISTRICT HEALTH APPRAISAL FORM

Name: _____

Date of Birth: _____ Age: _____

Date of exam: _____

Gender: _____

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: _____

Referral

Body Mass Index: _____ . _____	Vision - without glasses/contact lenses	R 20/	L 20/	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R 20/	L 20/	
<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 20/	L 20/	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R db	L db	

Tanner: I. II. III. IV. V. U/A: _____ Glucose _____ Protein _____ Scoliosis: Negative Positive: _____

Specify any abnormality during health examination (use reverse of form if needed): _____

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: cheerleading, gymnastics, ski, volleyball, cross-country, handball, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, weight train, 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: _____

Parent Signature: _____ Date: _____ revised 5/10