

Date of Exam: \_\_\_\_\_

NYSED required 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

**CORTLAND ENLARGED CITY SCHOOL DISTRICT  
HEALTH APPRAISAL FORM**

Name: \_\_\_\_\_  
School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Gender:  M  F Grade: \_\_\_\_\_

**IMMUNIZATIONS / HEALTH HISTORY**

Immunization record attached  
 No immunizations given today  
 Immunizations given since last Health Appraisal  
 Immunizations up to date  
Significant Medical / Surgical History:  See attached

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: \_\_\_\_\_

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: \_\_\_\_\_ U/A: \_\_\_\_\_

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Vision – without glasses/contact lenses Color: _____ Hyperopia: _____	R	L	<i>Referral</i>
	Vision – with glasses/contact lenses	R	L	
	Vision – Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

**Pertinent Health Information:**

Skin and Hair \_\_\_\_\_ Tanner stage: I. II.  
Eyes and Eyelids \_\_\_\_\_ III. IV. V.  
Ears and Eardrums \_\_\_\_\_  
Nose and Throat \_\_\_\_\_  
Teeth and Gums \_\_\_\_\_  
Thyroid and Lymph Nodes \_\_\_\_\_  
Chest and Heart \_\_\_\_\_  
Abdomen \_\_\_\_\_  
External Genitalia \_\_\_\_\_  
Bones and Joints \_\_\_\_\_  
Scoliosis \_\_\_\_\_  
Feet \_\_\_\_\_

**Immunizations:**

DPT \_\_\_\_\_  
OPV \_\_\_\_\_  
Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_  
MMR \_\_\_\_\_ PROQUAD \_\_\_\_\_  
TB Tine test \_\_\_\_\_ Results \_\_\_\_\_  
HIB \_\_\_\_\_  
HEP B \_\_\_\_\_  
HEP A \_\_\_\_\_  
Tdap \_\_\_\_\_ Td \_\_\_\_\_  
Pediatrix \_\_\_\_\_  
Gardasil \_\_\_\_\_  
Meningococcal \_\_\_\_\_  
Varicella \_\_\_\_\_

Other Observations: \_\_\_\_\_  
 EXAM ENTIRELY NORMAL Scoliosis:  Negative  Positive : \_\_\_\_\_  
Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

**PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION**

Free from contagious & 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, weigh 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's Signature: \_\_\_\_\_ Date: \_\_\_\_\_