Cheektowaga Central School District

NYSED requires physical exams for new entrants, students in Grades PK, K, 2, 4, 7, and 10, sports, working papers and triennially for CSE

Name:____ Grade: _____ M ☐ F ☐ Date of Birth: _________________

Immunizations/Health History

☐ Immunization record attached
☐ No Immunizations given today
☐ Immunizations given since last Health Appraisal: ______
____

Sickle Cell : ☐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: ☐ Typ
☐Other: ____

Allergies: ☐ LIFE THREATENING ☐Food: _______________ ☐Insect: _______________ ☐Other: ___________________
☐ Seasonal ☐ Medication: ____

Does the child have a history of concussion?____

Does this child have a history of: ___ chest pain ___ heart disease ___ lung disease

Is there a family history of sudden death from heart disease at a young age: ___Yes ___ No, if yes specify:___________________

Physical Examination

Height: ________________ Weight: ____________ Blood Pressure: _________ Date of Exam: _________________

<table>
<tr><td rowspan="4">Body Mass Index: _____ _____. _____
Weight Status Category (BMI Percentile):
☐less than 5th ☐5th through 49th ☐50th through 84th
☐85th through 94th ☐95th through 98th ☐99th and higher</td><td></td><td></td><td></td><td>Referral</td></tr>
<tr><td>Vision-w/o glasses/contacts:</td><td>R</td><td>L</td><td></td></tr>
<tr><td>Vision-with glasses/contacts:</td><td>R</td><td>L</td><td></td></tr>
<tr><td>Vision-Near point</td><td>R</td><td>L</td><td></td></tr>
<tr><td></td><td colspan="3">Hearing ☐Pass, 20db sc both ears or:</td><td></td></tr>
</table>

☐ **Exam Entirely Normal** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: ______________

Specify any abnormality (use reverse of form if needed): ____
____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medication listed on reverse of form

Name: ____ Dosage/Time: ____

Name: ____ Dosage/Time: ____

If AM dose is missed at home: ____

I assess this student to be self-directed: ☐ Yes ☐ No Student may self carry and self administer medication: ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softball
☐Non-contact: badminton, bowling, golf, swimming, table tennis, tennis, archery, riflery, weight training, crew, dance, track, run, walk

☐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: _________________

Provider's Signature: ____ Phone: ___________________

Provider's Name/Address: ____ Fax: _____________________

Parent Signature: ____ Date: ____________________

This exam complies with NYSED requirements and is valid for twelve months, with the exemption of any illness or injury lasting more than five days that will require review by the private healthcare provider and the school medical director.

revised 1/2015