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: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ 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: _____

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

☐ **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.