

Shoreham-Wading River Central School District
 Shoreham, N.Y. 11786
 631-821-8100

finHEALTH EXAMINATION

Name: _____ Date of Birth: _____
 School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal: _____

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 _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

U/A : Glucose _____ / Protein _____

Femoral pulses-Aortic Coarctation [] Yes [] No Heart Murmur [] Yes [] No Marfan Syndrome Physical Stigmata [] Yes [] No

Referral

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<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	L	
<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	L	

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 medications 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

Please Circle Sport of interest!

physically qualified for all playground, physical education, full contact /collision sports: field hockey, football, lacrosse, soccer, wrestling

___ Limited - contact: cheerlead, gymnastic, volleyball, cross-country, baseball, softball, basketball

___ Non --contact: golf, tennis, track

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.

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ADDITIONAL INFORMATION, if known

Specify current conditions: Asthma Diabetes: Type 1 Type 2 Seizures Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Additional Medical Information:

Additional Medication Information:
