Keshequa Central School
13 Mill Street, PO Box 517
Nunda, NY 14517

Dalton Elementary
Nurse: Noreen Sanford, RN
Phone: (585) 476-2234 x1148

Nunda Middle/ High
Nurse: Nedra Stevens, RN
Phone: (585) 468-2541 x2027

NYSED requires 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 (CSE).

HEALTH APPRAISAL FORM Date:_____

Name: _____ **Date of Birth:** _____

School: _____**Keshequa Central School (Middle/ High)** _ _____**Gender:** ☐ **M** ☐ **F** **Grade:** _____

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:** _____ **Urinalysis**:_____ **Date of Exam:**_____

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile) :
☐ Less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th or higher

	R	*L*	*Referral*
Vision – without glasses / contact lenses			
Vision – with glasses / contact lenses			
Vision – Near Point			
Hearing ☐ **Pass** 20 db 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 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

☐ **Free from contagions & 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, weight 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: _____ Date:_____

Parent Signature: _____ Date: _____

**** This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting***