NYSED requires an annual physical exam for new entrants, students in Grades Pre-K, K, 2,4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

GERMAN INTERNATIONAL SCHOOL NEW YORK HEALTH APPRAISAL FORM

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:

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 _____

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

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ 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 and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ 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 and OTC medications may be 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: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

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

Provider's Name/Address: _____ Fax: _____

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 more than five days that will require review by private healthcare provider and the school medical director. *Rev. 5/17*

Student Name _____ Date of Birth _____

TUBERCULIN TESTING / SCREENING: A or B must be completed by Physician

A. PPD Date placed _____ Read _____ Result _____

If positive, a chest X-Ray with clearance in writing is required.

Chest X-Ray Date _____ Result _____

B. Tuberculin screening not indicated Date _____

Signature _____

PRESCRIPTION MEDICATIONS

Medication _____ Dosage/ Time/ Route_____

Medication _____ Dosage/ Time/ Route_____

Medication _____ Dosage/ Time/ Route_____

If AM dose is missed at home _____

I attest this student is self-directed __Yes __No Student may carry and self-administer __Yes __No

Note: Students are not permitted to carry or self-administer USDEA controlled drugs. Please advise parent to send in additional medication in the event of emergency or if morning medication has not been given.

PERMISSION TO RECEIVE PRESCRIPTION AND OVER THE COUNTER MEDICATION

Health Care Provider and Parent signature REQUIRED

___ Tylenol (pain, fever) Dose _____ Freq. _____ Route _____

___ Ibuprofen (Advil/ Motrin) (pain, fever) Dose _____ Freq. _____ Route _____

___ Benadryl (allergic reaction/ allergy) Dose _____ Freq. _____ Route _____

___ Antacid (Maalox, Tums) (abdominal discomfort) Dose _____ Freq. _____ Route _____

___ Cough Drops/ Throat Lozenges (sore throat) Dose _____ Freq. _____ Route _____

___ Antibiotic Ointment (skin lesions) Dose _____ Freq. _____ Route _____

SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE TO DISPENSE MEDICATION OF ANY KIND

(*May use stamp below*)

Physician/ Practitioner Signature _____ Phone _____

Name / Address_____ Fax _____

**** Parent Signature _____ Date _____

Parental signature authorizes school nurse to communicate with your child's physician regarding prescription and over the counter medication.