

MOUNT SINAI UNION FREE SCHOOL DISTRICT

School/Interscholastic Sports Health Appraisal Form

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

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached PPD: Positive Negative Not done Date: _____
 No immunizations given today Elevated Lead: Yes No Not done Date: _____
 Immunizations given since last Health Appraisal: 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: _____

Body Mass Index: _____ . _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses	R	L	Referral
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	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): _____

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)

THIS FORM MUST BE COMPLETED BY A DULY LICENSED HEALTH CARE PROVIDER WHO IS AUTHORIZED TO PRACTICE IN NEW YORK STATE (Physician, Nurse Practitioner, or Physician's Assistant)

**** ALL PHYSICALS MUST BE COMPLETED ON OR AFTER JUNE 1 TO BE VALID AND WILL ONLY BE RECOGNIZED FOR THAT SCHOOL YEAR ****