

# 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 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> 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\*\***