

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, Interscholastic athletics, working permits, and triennially for the Committee on Special Education (CSE). A dental health certificate is also requested.

PHYSICIAN'S HEALTH APPRAISAL FORM
Chappaqua Central School District

Name: _____ Date of Birth: _____ Gender: M F
 School: _____ Grade: _____ Home Phone: _____
 Work: (_____) _____ Cell / Contact Phone: (_____) _____

IMMUNIZATIONS/HEALTH HISTORY

Immunization record attached
 TB testing: Low Risk/not indicated PPD Date: _____ Positive Negative
SIGNIFICANT MEDICAL / SURGICAL HISTORY None See attached Other (specify below)

Allergies No Yes If yes: Food Insect Latex Medication Other: _____
Specify: _____
 LIFE THREATENING (**Specify:** _____) Benadryl prescribed EpiPen prescribed
Medication Administration forms for Benadryl and EpiPen must be completed by physician and attached.

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Body Mass Index: (Required): _____ % Age _____ Weight Status Category (BMI Percentile): (Required): Male _____ % Female _____ %	Vision — without glasses/contact lenses	R	L	<i>Referral</i>
	Vision — with glasses/contact lenses	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: _____

MEDICATIONS

Medications (list below) : None
 1. _____ 3. _____
 2. _____ 4. _____

PHYSICAL EDUCATION / SPORTS/ PLAYGROUND

Full participation in all physical education, sports, playground, work & school activities
 Limited participation Specify: _____

Physician's Signature: _____ **Date of exam:** _____

Provider's Name / Address: _____ **Phone:** _____

Provider's Stamp: (required)

HEALTH HISTORY
Parent Section
CHAPPAQUA CENTRAL SCHOOL DISTRICT

Name: _____ Date: _____

Address: _____ Grade entering (as of Sept.) _____

Home Phone: _____ Cell / Contact Phone: (_____) _____ Date of Birth: _____

School Attending: HGHS Seven Bridges Robert E. Bell

List the specific sports in which your child will be participating for each season:

Fall: _____ Winter: _____ Spring: _____

Required Past Medical History (to be completed by parent / guardian)

	Yes	No	Dates / Details
Hospitalizations			
Operations / Surgery			
Daily Medications			
Allergies			
Significant Illnesses and/or Injuries			
Current conditions being monitored by a physician			

Required for Sports Participation - Additional History (to be completed by parent / guardian)

	Yes	No	Dates / Details
Ever denied full athletic participation?			
Absence of a paired organ			
Anemia			
Asthma / respiratory disorder			
Concussion (Number ____)			
Frequent or Severe Headaches			
Fainting / passing out			
Heat exhaustion / heat stroke			
Heart disease - student			
Heart disease - family			
Hypertension			
Mononucleosis			
Seizures / epilepsy			
Describe any major musculo-skeletal injury or problem that occurred in the last 3 years			

Parent / Guardian Attestation (For All Sports Participation)

I declare that the above information is an accurate and true reflection of my child's condition.

Parent /Guardian Signature: _____ Date: _____