

# HEALTH APPRAISAL FORM

PENFIELD CENTRAL SCHOOL DISTRICT

Our Lady of Mercy High School HEALTH OFFICE 1437 Blossom Rd. Rochester, NY 14610 288-7120 X 314 Fax 288-7966

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F

## 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: \_\_\_\_\_  Seasonal \_\_\_\_\_  Other: \_\_\_\_\_

Medication: used for ALLERGIC REACTION: Epi- Pen \_\_\_\_\_ Benadryl \_\_\_\_\_

## PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_ *Referral*

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<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>	Vision - Near Point	R	L	
<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	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): \_\_\_\_\_

## MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Permission for OTC Pain Medication to be given by school nurse PRN \_\_\_\_\_

Acetaminophen \_\_\_\_\_mg q 4 hours OR Ibuprofen \_\_\_\_\_mg q 4 hours OR Midol \_\_\_\_\_ tabs q 4 hours.

If AM dose is missed at home School Nurse may administer with parent notification.

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 / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, 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, rifer, 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:  Sport goggles/impact resistant eyewear  Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ DATE: \_\_\_\_\_ (Stamp below)

Provider's Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent Signature (required for any medications given in school) \_\_\_\_\_ Date \_\_\_\_\_

Your health care provider may or may not require the release of information form below to share Protected Medical Information with the school district or school. Please sign and give the form to your healthcare provider (if required) or your school nurse to avoid delays.

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ authorize my child's healthcare provider(s) listed below to release the medical records of my child \_\_\_\_\_, to the Penfield Central School District's Medical Officer, Dr. Cynthia Devore, the School Nurse, Occupational Therapist, Physical Therapist (PT), Athletic Trainer, or Speech Therapist (ST):

Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

The healthcare provider may disclose the following protected health information: (check all that apply)

- Immunizations
- Health Appraisals
- Past/Current Medical Condition and Its Impact on Attendance or School Programming or need for therapy
- Other \_\_\_\_\_

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery or therapy prescriptions
- At patient's request with no specified purpose
- Other \_\_\_\_\_

Please select one:

- This authorization is valid for the entire academic school year 20 \_\_\_\_ - 20 \_\_\_\_
- This authorization shall expire on \_\_\_\_\_ I (MOIDDIYR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the School Nurse.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for Disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and Federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment may not be dependent on my agreement to release or withhold information.

Date \_\_\_\_\_ Signature of Patient, \_\_\_\_\_ Parent, or Guardian Relationship

**YOU MAY Refuse TO SIGN THIS AUTHORIZATION**

A signed copy of this authorization must be given to the adult patient or parent of the minor child

ADDITIONAL INFORMATION :( Continued from Front)

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