Buffalo Seminary Health Appraisal Form

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NYS Law requires that a Health Appraisal Form be completed annually to participate on ANY school sports team.
Buffalo Seminary requires a physical for all new entrants and sophomores.

Name: Date of Birth: Grade:

Address: Phone:

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: _____
Lead Screen: ☐ Positive ☐ Negative ☐ Not Done Date: _____
Dental Referral: ☐ Positive ☐ Negative ☐ Not Done Date: _____

Significant medical/surgical history: ☐ See attached

Specific current diseases: ☐ Asthma ☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension ☐ Other:

Asthma Severity: ☐ intermittent ☐ mild persistent ☐ moderate persistent ☐ severe persistent ☐ inhaler

Allergies: ☐ LIFE THREATENING ☐ food: _____ ☐ insect: _____ ☐ seasonal: _____ ☐ other: _____ ☐ medication:

PHYSICAL EXAM

Height: Weight: BMI: BP: 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	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ Check here if entire exam is normal Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive

Specify any abnormality (use reverse of form if needed):

MEDICATIONS

Medications (list all): ☐ None ☐ Yes, see attached list

Name: Dosage/Time:

Name: Dosage/Time:

I assess this student to be self-directed ☐ YES ☐ NO Student may self-carry and self-administer medication: ☐ YES ☐ NO

Note: School nurse to also assess self-direction

Parent's Name: Parent's Signature:

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ Free from contagions & physically qualified for all physical education, sports, play, work & school activities as checked below:

_____ Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, etc.

_____ Limited contact: cheerleading, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softball.

_____ Non-contact: badminton, bowling, golf, swim, table tennis, tennis, weight training, crew, dancing, track, run, walk, rope jumping.

☐ Specify medical accommodations needed from school: _____ ☐ None

☐ Known or suspected disability: _____ ☐ Please Monitor

☐ Restrictions: _____ ☐ Please Monitor

☐ Protective equipment required: ☐ Glasses/eyewear ☐ Other: _____

Provider's Signature: Date:

Provider's Name/Address: Fax:

Parent Signature:

This exam complies with NYSED requirements above and is valid for one year through the last day of the month dated below, with the exception of any illness or injury lasting more than five days that will require review by health care provider and school nurse.