Galway Central School
Student Health Appraisal

Student Name _____Gender □ M □ F
Date of Birth: _____ Grade Level_____

Significant Medical/Surgical History □ See attached

_____

_____

Does this child have any of the following? □ Asthma □ Diabetes I/II (circle)
□ Hyperlipidemia □ Hypertension □ Seizure disorder

***Medications*:** □ none □ See attached list

Name: _____ **Dosage/time:** _____
Name: _____ **Dosage/time:** _____
Name: _____ **Dosage/time:** _____

I assess this student to be self-directed* □yes □no Student may carry/self-administer med* □yes □no
If am dose missed at home*: _____

**Note: nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event of an emergency or if morning medication has not been given.*

Allergies: □ **Life Threatening*** □ Food:_____ □ Insect:_____
□ Medication allergy: _____Reaction: _____

**Please note: If this child has a life threatening allergy, please submit an Allergy Action Plan*

Physical Exam

Blood Pressure _____Pulse _____
Height _____Weight_____ BMI_____

Weight status category (BMI percentile): □ <5% □ 5-49 % □ 5-49 % □50-84 % □ 85-94 % □ 95-98 % □ >99%

Vision Screen: R:_____ L: _____ Hearing Screen: *Right*_____
*Left*_____ With glasses: □yes □no Referral : □yes □no (Please include numeric value) Referral □ yes □ no

	Normal	Abnormal		Normal	Abnormal
General ……	□	□	Heart ……	□	□
Eyes ……	□	□	Abdomen……	□	□
Ears ……	□	□	Genitalia …….....	□	□
Nose/throat ……	□	□	Hernia exam..…….....	□	□
Teeth ……	□	□	Peripheral pulses ……...	□	□
Skin ……..	□	□	Scoliosis screen…….. ……..	□	□
Thyroid ……	□	□	Shoulders/Arms/Wrists/Hands	□	□
Lungs ……...	□	□	Knees/Hips…….	□	□
Tanner Stage …… 1 2 3 4 5			Ankles/ Feet ……..	□	□

Details of Abnormal Findings _____
_____

Immunization Record/Health Screening

□ Immunization record attached Sickle cell Screen □positive □negative □not done/ind. Date___
□ No immunizations given today PPD □positive □negative □not done/ind. Date___
□ Immunizations given since last health appraisal: Elevated Lead □positive □negative □not done/ind. Date___
_____ Dental Referral □yes □no

Part 4: Physical Education/ Sports/ playground/ CSE Consideration

□ Free from contagions & physically qualified for all physical education, sports, playground, work, & social activities OR

□Limited contact

□Noncontact

□ Specify medical accommodations needed for school : _____

_____

□ Known or suspected disability: _____

□ Restrictions: _____

□ Protective equipment required: _____

Part 5: Signature and Office information

Physician Signature_____ Date _____

Physician Name (print) _____

Address: _____

Phone number: _____ Fax