School District of the City of Niagara Falls
Department of Health Services

PHYSICAL EXAMINATION

Name_____**D O B**_____**School**_____

***I hereby grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child's health care provider pertaining to the information indicated in this physical.**

_____ _____

Parent/guardian Signature **Parent/guardian printed name**

IMMUNIZATIONS/HEALTH HISTORY

□ **Immunization record attached**	**Sickle Cell Screen:**	□ **Positive**	□ **Negative**	□ **Not done** **Date:**_____
□ **No Immunization given today**	**PPD:**	□ **Positive**	□ **Negative**	□ **Not done** **Date**_____
□ **Immunizations given since last appraisal**	**Elevated Lead**	□ **Yes**	□ **No**	□ **Note done** **Date**_____
	Dental Referral	□ **Yes**	□ **No**	□ **Not done** **Date**_____

Significant Medical/Surgical History: ___SEE ATTACHED

_____

Allergies: ___Life Threatening ___Food:_____ __Insect:_____ __ Other:_____

___ Seasonal ____ Medication: _____

PHYSICAL EXAM

Date of exam: _____Height:_____ Weight_____ Vision R_____ L_____ B.P._____ Pulse_____

Body Mass Index___ ___.__ BMI Percentile: __ < 5 % __5% - 49% ___50% - 84% __85% - 94% ___95%-98% __99% and higher

☐ **EXAM ENTIRELY NORMAL specify any abnormality (use reverse of form if needed):**_____

_____

Scoliosis: ___Negative ___Positive

Menarche _____ LMP_____ Testes _____ Tanner Stage I II III IV V

*******PLEASE SPECIFY CURRENT DISEASES:*** ___Asthma ___ Diabetes: ___Type 1 ___Type 2

___Hyperlipidemia ___Hypertension

MEDICATIONS

Medication: ☐ **None** ☐ **Medication at home only** ☐ **Medication to be given at school**

Name:_____

Dosage/Time:_____

(list additional medications on reverse of form)

If AM dose is missed at home:_____

I assess this student to be self- directed and may self-carry medication ☐ Yes ☐ No

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

(*Interscholastic sports participants must be seen by the District Nurse Practitioners)*

____ **Free from contagions & physically qualified for all physical education, sports, playground, work and school activities OR only as checked below:**

____ Limited contact: baseball, basketball, softball, volleyball, diving

____ Strenuous/non-contact: cross country, track & field, swimming, tennis, indoor track

____ Non strenuous/non-contact: bowling, golf, cheerleading

____ **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_____

Provider's Signature:_____Phone:_____ (stamp below)

Provider's Name/Address:_____ Fax: _____

NYSED requires an annual exam for new entrants, students in grades Pre-K or K,2,4,7,& 10, sports, working permits and triennially for the Committee on Special Education (CSE). *F 16a rev. 2/11*