

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: _____

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher		Vision - without glasses/contact lenses	R	L	<i>Referral</i>
		Vision - with glasses/contact lenses	R	L	
		Vision - Near Point	R	L	
		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)
