YESHIVA DARCHEI NOAM

Health Appraisal/Physical Form

Name: _____ **Grade** _____ **Date of Birth:** _____

IMMUNIZATIONS / HEALTH HISTORY

❒ No immunizations given today ❒ Immunizations up-to-date
❒ Immunization record attached

PPD: ❒ Positive ❒ Negative ❒ Not done Date: _____
Elevated Lead ❒ Yes ❒ No ❒ Not done Date: _____
Labs: U/A_____ ❒ Other_____

Significant Medical/Surgical History: ❒ see Attached_____

Specify current diseases: ❒ **Asthma** ❒**Seizures** **Diabetes:** ❒**Type 1** ❒**Type 2** ❒ **Hypertension** ❒ **Other**

ALLERGIES: ❒ **LIFE-THREATENING** ❒ NON LIFE-THREATENING ❒ Insect_____ ❒ Medication_____ ❒ Latex_____
❒ Food_____ ❒ Seasonal_____ ❒ Other_____

PHYSICAL EXAM

Height_____ Weight_____ BMI_____ *Percentile* ❒ < 5th ❒ 5th to 49th ❒50th to 84th ❒85th to 94th ❒95th to 98th ❒ >99th

B/P _____ Pulse _____ Heart_____ Lungs_____ **Scoliosis** ❒ Negative ❒ Positive_____

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V.
❒ Specify and abnormality_____

Vision Right 20/___ Left 20/___ with Lenses ❒
Hearing ❒ Pass 20 db sc both ears or: R_____L____

MEDICATIONS

❒ Medications (list all): ❒ None ❒ Additional medications listed on reverse of form ❒ if AM dose is missed at home give in school

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

Authorization for Administration of Medication in School including OTC Medication

Parents will be notified prior to administrating medication to students

MEDICATION	DOSE	ROUTE	TIMES TO BE ADMINISTERED	INDICATIONS	COMMENTS
Tylenol (acetaminophen)					
Advil (ibuprofen)					
Tums					
Benadryl (diphenhydramine HCl)					

Recommendation or Restriction for Participation in Physical Education/Sports/Work:

❒Free from contagions and physically qualified for all activities (phys ed. athletics, playground, work, school)
❒Recommendation/restrictions_____

All information contained herein is valid through the last day of the month for 12 months from the date below

Medical Provider Signature: _____ Date_____
Provider's Name/Address: _____ (Stamp Below)

Parent Signature: _____

Return to: YESHIVA DARCHEI NOAM ❖ 257 GRANDVIEW AVENUE ❖ SUFFERN, NY 10901 ❖ 845.352.7100 ❖ F: 845.352.9593