



**Bethlehem Central
School District**
Office of the Registrar
90 Adams Place
Delmar, NY 12054
(518) 439-7481

PHYSICAL APPRAISAL REPORT
(Required **BEFORE** students enters grades 2, and 4)

Home School (Please circle one) CLK EAG ELS GLE HAM SLI

Student Name _____ Grade _____ M or F (please circle)

Address _____ Town _____ Zip Code _____ Phone _____

Date of Birth _____

Teacher _____

Parent or guardian: Please bring this form to school after completion by your child's physician.

HEALTH HISTORY

- | | | |
|----------------------------|-----------------------------|--------------------------|
| _____ Allergies | _____ Eye Conditions | _____ Scarlet Fever |
| _____ Bee sting | _____ Hearing Problem | _____ Seizures |
| _____ Food | _____ Heart Disease | _____ With fever |
| _____ Other | _____ Hyperkinesis | _____ Without fever |
| _____ Anemia | _____ Kidney Disease | _____ Speech Problem |
| _____ Asthma | _____ Learning Disabilities | _____ Strep Throat |
| _____ Cerebral Palsy | _____ Leukemia | _____ TB |
| _____ Chicken Pox | _____ Measles Disease | _____ Chest X-ray |
| _____ Colds & Sore Throats | _____ Mononucleosis | _____ TB Contact |
| _____ Cystic Fibrosis | _____ Mumps Disease | _____ TB test results |
| _____ Diabetes | _____ Orthopedic Conditions | _____ Urinary Infections |
| _____ Ear Infections | _____ Pneumonia | _____ Vision Problem |
| _____ PE Tubes | _____ Rheumatic Disease | _____ Whooping Cough |
| | _____ Rubella Disease | |

Problems at birth _____

Serious injuries _____

Surgeries _____

Other concerns _____

Please list all over the counter and prescription medications, including dose and frequency: _____

Are there any physical restrictions or limitations for physical education class or other activities in school?

Yes _____ No _____ If yes, list _____

PHYSICAL

Immunizations during past year (List type, month, day, year) _____

Height _____ Weight _____ Body Mass Index _____

Weight Status Category:

- Less than 5th 5th through 49th 50th through 84th 85th through 94th 95th through 98th 99th and higher

Blood Pressure _____ Normal Pulse _____

Eyes (R) _____ (L) _____ Ears (R) _____ (L) _____ Tonsils _____

Teeth _____ Cervical _____ Thyroid _____ Other _____ Heart _____

Lungs _____ Abdomen _____ Hernia _____ Nervous System _____ Posture _____

Orthopedic _____ Scoliosis (see reverse if positive) _____ Feet _____ Skin _____

Genitourinary _____ Urine testing: Sugar _____ Protein _____

Tanner: Male / Female 1 2 3 4 5 Female – Onset Menstruation _____

General Condition _____

Recommendations _____

Physician's Signature _____ **Date of exam** _____

Physician's Name or Stamp _____

Student's name _____ Grade _____ Date of exam _____

Additional health history information: _____

SCOLIOSIS SCREENING

Effective September 1982, New York State Law requires annual scoliosis screening for each child between the ages of 8 and 16.

Please check any positive findings:

- | | | |
|------------------------------|-------|-------|
| 1. Forward bend | | |
| Thoracic prominence | L () | R () |
| Lumbar prominence | L () | R () |
| 2. Shoulder higher | L () | R () |
| 3. Prominent scapula | L () | R () |
| 4. Elevated scapula | L () | R () |
| 5. Iliac crest higher | L () | R () |
| 6. Arm to body space greater | L () | R () |
| 7. Recommendations: | | |

Screened by: _____

Physician's name or stamp: _____