St. Thomas School

St. Thomas the Apostle School Health Office
42 Adams Place · Delmar, NY 12054
(518)439-5573 Phone · 518-478-9773 fax

FORM D

Physical Appraisal Report (Page 1)

_____ ___/___/_____ ☐Male ☐Female
Student Name (Last, First) Date of Birth

_____ _____ _____ _____
Address City Zip Phone

_____ _____
Teacher Grade

☐ Allergies	☐ Seizures	☐ Hypotonia	☐ Rubella Disease
☐Bee Sting	☐ With Fever	☐ Kidney Disease	☐ Scarlet Fever
☐Food	☐ Without Fever	☐ Learning Disabilities	☐ Seizure Disorder
☐Medication	☐Cystic Fibrosis	☐ Leukemia	☐ Speech Problem
☐Other	☐ Diabetes	☐ Measles	☐ Strep Throat
☐ Anemia	☐ Ear Infections	☐ Mononucleosis	☐ TB
☐ Asthma	☐ History of PE Tubes	☐ Mumps	☐ Chest X-ray
☐ Cerebral Palsy	☐ Eye Conditions	☐ Orthopedic Conditions	☐ Urinary Infections
☐ Chicken Pox	☐ Hearing Problems	☐ Pneumonia	☐ Vision Problem
☐ Colds & Sore Throats	☐ Heart Disease	☐ Rheumatic Disease	☐ Whooping Cough

Problems at birth: _____

Serious Injuries: _____

Other Concerns: _____

Restrictions or limitations for physical education class or other activities in school?
☐Yes ☐No If yes, please list: _____

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

Height _____ Weight _____ Body Mass Index _____ _____ . _____

Weight Status Category: ☐Less than 5th ☐5th - 49th ☐50th – 84th ☐85th – 94th ☐95th – 98th ☐99th & higher

Blood Pressure	_____	Pulse	_____	Eyes (R)	_____	Eyes (L)	_____
Ears (R)	_____	Ears (L)	_____	Tonsils	_____	Teeth	_____
Teeth	_____	Cervical	_____	Thyroid	_____	Heart	_____
Lungs	_____	Abdomen	_____	Hernia	_____	Posture	_____
Nervous System	_____	Orthopedic	_____	Feet	_____	Skin	_____
Genitourinary	_____	Urine Testing:	Sugar: _____	Protein: _____			
Scoliosis*	_____	**If scoliosis is positive, please complete page 2.*					

General Condition: _____

Recommendations: _____

Physician's Signature: **Date:**

Physician's Name/Stamp:

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FORM D

Physical Appraisal Report (Page 2)

_____	_____	____/____/_____
Student 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:

Forward Bend		
Thoracic Prominence	☐L	☐R
Lumbar Prominence	☐L	☐R
Shoulder Higher	☐L	☐R
Prominent Scapula	☐L	☐R
Elevated Scapula	☐L	☐R
Iliac Crest Higher	☐L	☐R
Arm to body space greater	☐L	☐R

Recommendations:

_____

_____

Screened by:	**Date:**

Physician's Name or Stamp: