

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: _____	<input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HgbA1c results: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 **Percentile (Weight Status Category):** <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and <

Hyperlipidemia: No Yes **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____
<input type="checkbox"/> System Review and Exam Entirely Normal				
Check Any Assessment Boxes <u>Outside</u> Normal Limits And Note Below Under Abnormalities				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code
			_____	_____
			_____	_____
			_____	_____
<input type="checkbox"/> Additional Information Attached				

Name:

DOB:

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

- Full Activity** without restrictions including Physical Education and Athletics.
- Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications
- No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- Other Restrictions:**
- Developmental Stage for Athletic Placement Process ONLY**
Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports
Student is at **Tanner Stage:** I II III IV V
- Accommodations:** Use additional space below to explain
- | | | |
|---|---|---|
| <input type="checkbox"/> Brace*/Orthotic | <input type="checkbox"/> Colostomy Appliance* | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Insulin Pump/Insulin Sensor* | <input type="checkbox"/> Medical/Prosthetic Device* | <input type="checkbox"/> Pacemaker/Defibrillator* |
| <input type="checkbox"/> Protective Equipment | <input type="checkbox"/> Sport Safety Goggles | <input type="checkbox"/> Other: |
- *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

- Order Form for Medication(s) Needed at School attached**

List medications taken at home:

IMMUNIZATIONS

 Record Attached Reported in NYSIISReceived Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:

Date:

Provider Name: (please print)

Stamp:

Provider Address:

Phone:

Fax:

Please Return This Form To Your Child's School When Entirely Completed.