

St. Mary's School
Nursing Office
12 Sixth St., Waterford, New York 12188
(518) 237-0652 fax (518) 233-0898

Dear Parent/Guardian,

Date:

Education Law requires all New York State (NYS) public school students to have a health exam when they are a new student in a school district and when they enter Pre-K or Kindergarten, and grades 1, 3, 5, 7, 9, and 11.

Beginning on 1/31/21, schools cannot accept the health exam if it is not on the required form or the required health record equivalent.

We have attached a letter and copy of the required form with instructions for your health care provider (HCP). The form and instructions are also on our website at www.schoolhealthny.com. Please share the attached papers at your child's visit for a health exam with the health care provider (HCP). This is typically your doctor but may be a nurse practitioner or physician assistant.

Sincerely,

School District Medical Director/Administrator

If you have questions, please contact:

Nurse: Ann M. Devine, RN School: St. MARY's School Waterford

Phone: 518- 237-0652 Fax: 518- 233-0898

Email: Devinea@smswaterford.org

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

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

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 Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5 \mu\text{g/dL}$				
<input type="checkbox"/> System Review and Abnormal Findings Listed Below				
<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				

*Required only for students with an IEP receiving Medicaid

Name: _____ DOB: _____

SCREENINGS

Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes				<input type="checkbox"/>

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.

Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	Not Done
Notes				<input type="checkbox"/>

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

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

- Student may participate in all activities without restrictions.
- Student is restricted from participation in:
 - Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
 - Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
 - Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
 - Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: I II III IV V Age of First Menses (if applicable) : _____

Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

Order Form for Medication(s) Needed at School Attached

IMMUNIZATIONS

Record Attached Reported in NYSIS

HEALTH CARE PROVIDER

Medical Provider Signature: _____

Provider Name: *(please print)* _____

Provider Address: _____

Phone: _____

Fax: _____

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