

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: M F DOB: _____
 School: _____ Grade: _____ Exam Date: _____

HEALTH HISTORY

Allergies No Medication/Treatment Order Attached Anaphylaxis Care Plan Attached
 Yes, indicate type Food Insects Latex Medication Environmental

Asthma No Medication/Treatment Order Attached Asthma Care Plan Attached
 Yes, indicate type Intermittent Persistent Other: _____

Seizures No Medication/Treatment Order Attached Seizure Care Plan Attached
 Yes, indicate type Type: _____ Date of last seizure: _____

Diabetes No Medication/Treatment Order Attached Diabetes Medical Mgmt. Plan Attached
 Yes, indicate type Type 1 Type 2 HbA1c results: _____ 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 $\geq 10 \mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside 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

Assessment/Abnormalities Noted/Recommendations:

	Diagnoses/Problems (list)	ICD-10 Code
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Information Attached

Name:

DOB:

SCREENINGS

Vision	Right	Left	Referral	Notes
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Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Distance Acuity With Lenses	20/	20/		
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Vision – Near Vision	20/	20/		
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Vision – Color Pass Fail

Hearing	Right dB	Left dB	Referral
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Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No
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Scoliosis	Negative	Positive	Referral
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Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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

Brace*/Orthotic

Colostomy Appliance*

Hearing Aids

Insulin Pump/Insulin Sensor*

Medical/Prosthetic Device*

Pacemaker/Defibrillator*

Protective Equipment

Sport Safety Goggles

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 NYSIIS

Received 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.