

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"/> Medication/Treatment Order Attached | <input type="checkbox"/> Anaphylaxis Care Plan Attached |
| <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication | <input type="checkbox"/> Environmental |

| | | |
|---|---|--|
| Asthma <input type="checkbox"/> No | <input type="checkbox"/> Medication/Treatment Order Attached | <input type="checkbox"/> Asthma Care Plan Attached |
| <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: _____ | |

| | | |
|---|--|---|
| Seizures <input type="checkbox"/> No | <input type="checkbox"/> Medication/Treatment Order Attached | <input type="checkbox"/> Seizure Care Plan Attached |
| <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Type: _____ | Date of last seizure: _____ |

| | | |
|---|---|---|
| Diabetes <input type="checkbox"/> No | <input type="checkbox"/> Medication/Treatment Order Attached | <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached |
| <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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 One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle <input type="checkbox"/> Concussion – Last Occurrence: _____ <input type="checkbox"/> Mental Health: _____ <input type="checkbox"/> Other: _____ |
| PPD/ 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 > 10 µg/dL | | | | |

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 |

| | | |
|--|---------------------------|-------------|
| <input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations: | Diagnoses/Problems (list) | ICD-10 Code |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

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 NYSIS
- Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: (please print)

Provider Address:

Phone:

Fax:

Date:

Stamp:

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