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| REQUIRED NYS SCHOOL HEALTH EXAMINATION FORMTO 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: 🞎 M 🞎 F | DOB: |
| School: | Grade: | Exam Date: |
| HEALTH HISTORY |
| Allergies ☐ No☐ Yes, indicate type | Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| Asthma ☐ No☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| Seizures ☐ No☐ Yes, indicate type | Type: ☐ Medication/Treatment Order Attached |  Date of last seizure:  ☐ Seizure Care Plan Attached |
|  Diabetes ☐ No☐ Yes, indicate type  | Type: [ ]  1 [ ]  2  ☐ Medication/Treatment Order Attached |  ☐ 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 | [ ]  | [ ]  |  |  |
| Sickle Cell Screen-PRN | [ ]  | [ ]  |  |  |
| Lead Level Required Grades Pre- K & K  | **Date** |  |
| ☐ Test Done ☐ Lead Elevated > 5 µg/dL  |  |
| [ ]  System Review and Abnormal Findings Listed Below |
| [ ]  HEENT | [ ]  Lymph nodes | [ ]  Abdomen | [ ]  Extremities | [ ]  Speech |
| [ ]  Dental | [ ]  Cardiovascular | [ ]  Back/Spine | [ ]  Skin | [ ]  Social Emotional |
| [ ]  Neck | [ ]  Lungs | [ ]  Genitourinary | [ ]  Neurological | [ ]  Musculoskeletal |
| [ ]  Assessment/Abnormalities Noted/Recommendations:  |  Diagnoses/Problems (list) ICD-10 Code\* |
|  |  |  |
| [ ]  Additional Information Attached |  | \*Required only for students with an IEP receiving Medicaid |

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| **Name:** | **DOB:**  |
| **SCREENINGS** |
| **Vision** (w/correction if prescribed) | **Right** | **Left** | **Referral** | **Not Done** |
| Distance Acuity (passing is 20/30) | 20/ | 20/  | [ ]  Yes [ ]  No | [ ]  |
| Near Vision Acuity (passing is 20/40) | 20/ | 20/  |  | [ ]  |
| Color Perception Screening [ ]  Pass [ ]  Fail |  | [ ]  |
| Notes |  |  |
| **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. | **Not Done** |
| Pure Tone Screening | **Right**  [ ]  Pass [ ]  Fail | **Left**  [ ]  Pass [ ]  Fail | **Referral**  [ ]  Yes [ ]  No | [ ]  |
| Notes |  |  |  |  |
| **Scoliosis** ScreenBoys ingrade 9, and Girls in grades 5 & 7 | **Negative** | **Positive** | **Referral** |  **Not Done** |
|  |[ ] [ ]  [ ]  Yes [ ]  No | [ ]  |
|  |
| **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** forstudents in Grades 7 & 8who wishto 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, prostectic, 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 NYSIIS  |
| **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.** |

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