|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: 🞎 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 | | | | |

10/18/19 Page 1 of 2

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.** | | | | | | | | | |

2020 Page 2 of 2