

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

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

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

| | | |
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| <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 | | | | |
| <input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. | | | | |
| <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications | | | | |
| <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling | | | | |
| <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field | | | | |
| <input type="checkbox"/> Other Restrictions: | | | | |
| <input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V | | | | |
| <input type="checkbox"/> 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 | | | | |
| <input type="checkbox"/> Order Form for Medication(s) Needed at School attached | | | | |
| List medications taken at home: | | | | |
| | | | | |
| IMMUNIZATIONS | | | | |
| <input type="checkbox"/> Record Attached | | <input type="checkbox"/> Reported in NYSIIS | | Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HEALTH CARE PROVIDER | | | | |
| Medical Provider Signature: | | | Date: | |
| Provider Name: <i>(please print)</i> | | | Stamp: | |
| Provider Address: | | | | |
| Phone: | | | | |
| Fax: | | | | |
| Please Return This Form To Your Child's School When Entirely Completed. | | | | |