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 HgbA1c 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
PPD / PRN			
Sickle Cell Screen/PRN			

Lead Level- Test Done *Required Grades PreK and K*	**Lead Elevated** >10 µg/dL	**Date**

Other Pertinent Medical Concerns

One Functioning**:** ___Eye ___Kidney ___Testicle
___Concussion –Last Occurrence: ____________
___Mental Health: ____________
___Other:____________

_______**System Review and Exam Entirely Normal**

Check Any Assessment Outside Normal Limits And Note Below Under Abnormalities

____HEENT ____ Dental ____ Neck ____ Lungs ____ Skin ____ Back/Spine ____ Musculoskeletal
____ Genitourinary ____ Neurological ____ Lymph nodes ____ Abdomen
____ Cardiovascular ____ Extremities ____ Speech ____ Social Emotional _____

Assessment/Abnormalities Noted/Recommendations	Diagnoses/Problems (list)	ICD-10 Code

_____**Additional Information Attached**

5/1/2018

Name:____DOB:______________________

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	___Yes ___ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		

Vision – Color ____Pass ____Fail

Hearing	Right dB	Left dB	Referral	Notes
Pure Tone Screening			____Yes ____ No	

Scoliosis	Negative	Positive	Referral	Notes
Required for boys grade 9 and girls grades 5 & 7			___Yes ___ 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*

___Brace*/Orthotic ___Colostomy Appliance* ___Hearing Aids
___Insulin Pump/ 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 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