

**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: <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	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached	
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached	
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached	Date of last seizure:
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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:												
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:20%;">Laboratory Testing</th> <th style="width:10%;">Positive</th> <th style="width:10%;">Negative</th> <th style="width:10%;">Date</th> </tr> <tr> <td>TB- PRN</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Sickle Cell Screen-PRN</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td></td> </tr> </table>		Laboratory Testing	Positive	Negative	Date	TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<p align="center">List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</p>		
Laboratory Testing	Positive	Negative	Date													
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>														
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>														
<p>Lead Level Required Grades Pre- K & K</p> <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5 \mu\text{g/dL}$			<p>Date</p>													
<input type="checkbox"/> System Review and Abnormal Findings Listed Below																
<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*													
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid													

Name: _____ DOB: _____

Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11

Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

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 for students in Grades 7 & 8 who wish to 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, prosthetic, 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.