

**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: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached |
| 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: |
| Laboratory Testing | Positive | Negative | Date | List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ) |
| TB- PRN | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Sickle Cell Screen-PRN | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Lead Level Required Grades Pre- K & K | | | Date | |
| <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$ | | | | |
| <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: | |
| SCREENINGS | | | | | |
| 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 | | | | | |
| <input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> Other Restrictions: | | | | | |
| Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____ | | | | | |
| <input type="checkbox"/> 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 | | | | | |
| <input type="checkbox"/> Order Form for Medication(s) Needed at School Attached | | | | | |
| IMMUNIZATIONS | | | | | |
| | | <input type="checkbox"/> Record Attached | <input type="checkbox"/> Reported in NYSIIS | | |
| HEALTH CARE PROVIDER | | | | | |
| Medical Provider Signature: | | | | | |
| Provider Name: <i>(please print)</i> | | | | | |
| Provider Address: | | | | | |
| Phone: | | | Fax: | | |
| Please Return This Form To Your Child's School When Completed. | | | | | |