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 ○ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached; ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ○ No ○ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached; ☐ Intermittent ☐ Persistent ☐ Other: _____

Seizures ○ No ○ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached; ☐ Type: _____ Date of last seizure: _____

Diabetes ○ No ○ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached; ○ Type 1 ○ Type 2 ☐ HbA1c 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 Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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**	
Pure Tone Screening			◯ Yes ◯ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
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/Insulin 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 NYSIIS Received Today: ◯ Yes ◯ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.