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| **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:  M  F  | DOB:  |
| School:  | Grade:  | Exam Date:  |
| **HEALTH HISTORY**  |
| **Allergies** ☐ No☐ Yes, indicate type  | Type:  ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached  |
| **Asthma** ☐ No☐ Yes, indicate type  | ☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached  |
| **Seizures** ☐ No ☐ Yes, indicate type | Type: Date of last seizure:  ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached  |
|  **Diabetes** ☐ No☐ Yes, indicate type  | Type: ☐ 1 ☐ 2  ☐ Medication/Treatment Order Attached ☐ 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):**  <5**th**  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  | ☐  | ☐  |   |      |
| Sickle Cell Screen-PRN  | ☐  | ☐  |   |
| **Lead Level Required Grades Pre- K & K**  | **Date**  |
| ☐ Test Done ☐ Lead Elevated  **> 5** µg/dL  |   |
| ☐ **System Review and Abnormal Findings Listed Below**  |
| ☐ HEENT  | ☐ Lymph nodes  | ☐ Abdomen  | ☐ Extremities  | ☐ Speech  |
| ☐ Dental  | ☐ Cardiovascular  | ☐ Back/Spine  | ☐ Skin  | ☐ Social Emotional  |
| ☐ Neck  | ☐ Lungs  | ☐ Genitourinary  | ☐ Neurological  | ☐ Musculoskeletal |
| ☐ Assessment/Abnormalities Noted/Recommendations:  |  Diagnoses/Problems (list) ICD-10 Code\* |
|  ☐Additional Information Attached | \*Required only for students with an IEP receiving Medicaid  |

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| Name:  | DOB:  |
| **SCREENINGS**  |
| **Vision** (w/correction if prescribed) | **Right**  | **Left**  | **Referral**  | **Not Done**  |
| Distance Acuity  | 20/  | 20/  | ☐ Yes ☐ No  | ☐  |
| Near Vision Acuity  | 20/  | 20/  |   | ☐  |
| Color Perception Screening ☐ Pass ☐ Fail  |  | ☐ |
| 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**  ☐ Pass ☐ Fail | **Left**  ☐ Pass ☐ Fail | **Referral**  ☐ Yes ☐ No | ☐ |
| Notes  |  |  |  |   |
| **Scoliosis** ScreenBoys ingrade 9, and Girls in grades 5 & 7 | **Negative**  | **Positive**  | **Referral**  |  **Not Done**  |
| ☐  | ☐  | ☐ Yes ☐ No | ☐ |
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| **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** forstudents in Grades 7 & 8who wishto 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. Page 2 of 2** |