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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 | ☐ |
|  | | | | | | | |
| **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** | | | | | | | |