

**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: <input type="checkbox"/> M <input type="checkbox"/> F | DOB:       |
| School: | Grade:   | Exam Date: |

**HEALTH HISTORY**

|   |   |   |
|---|---|---|
| <b>Allergies</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached<br><input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication | <input type="checkbox"/> Anaphylaxis Care Plan Attached<br><input type="checkbox"/> Environmental |
|---|---|---|

|  |  |  |
|--|--|--|
| <b>Asthma</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached<br><input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____ | <input type="checkbox"/> Asthma Care Plan Attached |
|--|--|--|

|  |  |  |
|--|--|--|
| <b>Seizures</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached<br><input type="checkbox"/> Type: _____ | <input type="checkbox"/> Seizure Care Plan Attached<br>Date of last seizure: _____ |
|--|--|--|

|  |   |   |
|--|---|---|
| <b>Diabetes</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached<br><input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____ | <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):**  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  No  Yes      **Hypertension:**  No  Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

| Height:  | Weight:                  | BP:                      | Pulse:      | Respirations:   |
|--|--------------------------|--------------------------|-------------|---|
| <b>TESTS</b>   | <b>Positive</b>          | <b>Negative</b>          | <b>Date</b> | <b>Other Pertinent Medical Concerns</b>   |
| PPD/ PRN   | <input type="checkbox"/> | <input type="checkbox"/> |             | One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle |
| Sickle Cell Screen/PRN   | <input type="checkbox"/> | <input type="checkbox"/> |             | <input type="checkbox"/> Concussion – Last Occurrence: _____  |
| <b>Lead Level Required Grades Pre- K &amp; K</b>   |                          |                          | <b>Date</b> | <input type="checkbox"/> Mental Health: _____   |
| <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$ |                          |                          |             | <input type="checkbox"/> Other: _____   |

**System Review and Exam Entirely Normal**

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

|                                 |   |  |                                       |   |
|---------------------------------|---|--|---------------------------------------|---|
| <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 |
|  | _____                     | _____       |
|  | _____                     | _____       |
|  | _____                     | _____       |

Additional Information Attached

|       |      |
|-------|------|
| Name: | DOB: |
|-------|------|

**SCREENINGS**

| Vision   | Right                    | Left                     | Referral   | Notes |
|--|--------------------------|--------------------------|--|-------|
| Distance Acuity  | 20/                      | 20/                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |       |
| Distance Acuity With Lenses  | 20/                      | 20/                      |  |       |
| Vision – Near Vision   | 20/                      | 20/                      |  |       |
| Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail |                          |                          |  |       |
| Hearing  | Right dB                 | Left dB                  | Referral   |       |
| Pure Tone Screening  |                          |                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |       |
| Scoliosis  | Negative                 | Positive                 | Referral   |       |
| Required for boys grade 9<br>And girls grades 5 & 7                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> 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

|   |   |   |
|---|---|---|
| <input type="checkbox"/> Brace*/Orthotic              | <input type="checkbox"/> Colostomy Appliance*       | <input type="checkbox"/> Hearing Aids             |
| <input type="checkbox"/> Insulin Pump/Insulin Sensor* | <input type="checkbox"/> Medical/Prosthetic Device* | <input type="checkbox"/> Pacemaker/Defibrillator* |
| <input type="checkbox"/> Protective Equipment         | <input type="checkbox"/> Sport Safety Goggles       | <input type="checkbox"/> 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:          | <b>Date:</b> |
| Provider Name: <i>(please print)</i> | Stamp:       |
| Provider Address:                    |              |
| Phone:                               |              |
| Fax:                                 |              |

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