

**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 <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
---	---	---

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

<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <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

<b>Name:</b>	<b>DOB:</b>
--------------	-------------

**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 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**

<b>List medications taken at home:</b>		

**IMMUNIZATIONS**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Record Attached | <input type="checkbox"/> Reported in NYSIIS | Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> 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.**