|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:   * Medication/Treatment Order Attached | | | | Date of last seizure:   * 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 | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | | | | | DOB: |
| **Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11** | | | | | | | | | |
| **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** Screen Boys in grade 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** for students in Grades 7 & 8 who wish to 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.** | | | | | | | | | |