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): ☐ <5th ☐ 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
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	

Lead Level Required Grades Pre- K & K **Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **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:
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 Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative** ☐	**Positive** ☐	**Referral** ☐ Yes ☐ No / **Not Done** ☐

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, prostectic, 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.