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: □ M □ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐

Yes, indicate type ☐Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____ **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.

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

PHYSICAL EXAMINATION/ASSESSMENT

Height: Weight: BP: Pulse: Respirations:				
TESTS	**Positive**	**Negative**	**Date**	**Other Pertinent Medical Concerns**
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle ☐ Concussion – Last Occurrence: _____ ☐ Mental Health: _____ ☐ Other:
Sickle Cell Screen/PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated >10 µg/dL				

☐ **System Review and Exam Entirely Normal**

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

☐ HEENT ☐ Lymph nodes ☐ Abdomen ☐ Extremities ☐ Speech ☐ Dental ☐ Cardiovascular ☐ Back/Spine ☐ Skin ☐ Social Emotional ☐ Neck ☐ Lungs ☐ Genitourinary ☐ Neurological ☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations: ☐ Additional Information Attached	Diagnoses/Problems (list) ICD-10 Code _____ _____ _____ _____ _____ _____ _____ _____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision –Near Vision	20/	20/		
Vision –Color ☐Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	

And girls grades 5 & 7	☐	☐	☐ Yes ☐ 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

☐ Brace*/Orthotic ☐ Colostomy Appliance* ☐ Hearing Aids ☐ Insulin Pump/Insulin Sensor* ☐ Medical/Prosthetic Device* ☐ Pacemaker/Defibrillator* ☐ Protective Equipment ☐ Sport Safety Goggles ☐ 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:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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