HARRISON CENTRAL SCHOOL DISTRICT

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name:	DOB:	Gender: ☐ M ☐ F
School:	Grade: ☐NA	Exam Date:

HEALTH HISTORY

Specify Current Diseases

☐Asthma (☐Intermittent or ☐Persistent)
Quick relief inhaler: ☐Yes ☐No
Asthma Action Plan: ☐Yes ☐No
☐Type 1 Diabetes ☐Type 2 Diabetes
☐Hyperlipidemia ☐Hypertension
☐Other:

Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date:
PPD:	☐Positive	☐Negative	☐Not Done	Date:
Elevated Lead:	☐Yes	☐No	☐Not Done	Date:
Dental Referral:	☐Yes	☐No	☐Not Done	Date:

☐ Allergies - See page 2 for details.

Significant Medical/Surgical Information:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive
Degree of deviation: _____
Angle of trunk rotation via scoliometer: _____

Body Mass Index:
Weight Status Category (BMI Percentile):
☐ <5th ☐ 85th- 94th
☐ 5th- 49th ☐ 95th- 98th
☐ 50th-84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐Pass	☐Fail	

Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: ☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ See attached
Specify any abnormalities:

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)
☐ Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,
☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,
☐ Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking
☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:
☐ Medical/prosthetic device:
☐ Recommendations/restrictions:

Name: DOB:

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

***Self Directed**: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry**: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed

☐ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: Date: Phone: ( )

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: Date: Phone: ( )

ALLERGIES

☐ **None** ☐ **Non Life-Threatening** ☐ **Life-Threatening**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: ☐History of anaphylaxis; last occurrence:

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

IMMUNIZATIONS

☐ Immunization record attached
☐ Immunizations reported on NYSIIS
☐ No immunizations received today

☐ Immunizations received today:

☐ Will return on: to receive:

Provider / Parental Authorization

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: Date:

Provider Name: (please print) Phone #:

Provider Address: Fax #:

Parent/Guardian Signature: _____ Date:

Medical Provider Email:

Return to:

School Nurse: School:

Phone #: ( ) Fax: ( ) Date:

HARRISON CENTRAL SCHOOL DISTRICT
NEW STUDENT HEALTH HISTORY QUESTIONNAIRE

This New Student Health History Questionnaire is to be completed by the parent or guardian of an entering student who is new to the Harrison Central School District. The information provided in this questionnaire will provide the school nurse with important health-related information about your child.

Student Name: _____ **Date of Birth:** ___/___/___ **Gender:** ☐ **M** ☐ **F** **Grade:** _____

Father's Name: _____ **Mother's Name:** _____

Family Physician: _____ **Physician Phone #:** _____

Dentist: _____ **Dentist Phone #:** _____

HEALTH HISTORY

Please provide the following information about your child's health history.
If you answer "Yes" to any of the questions, ***please explain below.***

	Yes	No		Yes	No
Allergies to food or bee stings	☐	☐	Asthma	☐	☐
Allergies to medication	☐	☐	Any hospitalizations or ER visits (past 1 year)	☐	☐
Allergy to latex	☐	☐	Chronic illnesses	☐	☐
Allergies to animals	☐	☐	Diabetes	☐	☐
Seasonal allergies	☐	☐	Takes daily insulin or uses an insulin pump	☐	☐
Eczema or skin rashes	☐	☐	Bleeding disorders or frequent nosebleeds	☐	☐
Any daily medications	☐	☐	Chicken Pox	☐	☐
Any problems with vision	☐	☐	Mononucleosis (past 1 year)	☐	☐
Wears glasses or contact lenses	☐	☐	Measles	☐	☐
Dental braces, caps or bridges	☐	☐	Mumps	☐	☐
Any problems with hearing	☐	☐	Rubella	☐	☐
Wears a hearing aid	☐	☐	Whooping Cough	☐	☐
Frequent ear infections	☐	☐	Heart Disease	☐	☐
Any growth or developmental delays	☐	☐	Kidney Disease	☐	☐
Any prior concussions or head injuries	☐	☐	Lyme Disease	☐	☐
Any broken bones or dislocations	☐	☐	Migraine headaches	☐	☐
Any muscle or joint injuries	☐	☐	Pneumonia	☐	☐
Any neck or back injuries	☐	☐	Seizure Disorder	☐	☐
Any mobility limitations	☐	☐	Tuberculosis	☐	☐

Please explain all "Yes" answers below and include any other physical or mental health concerns not identified above.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature *Date*

HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue
Harrison, New York 10528
(914) 835-3300

DENTIST CERTIFICATE

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ **Date of Birth:** _____

Home Address: _____

School: _____ **Grade Level:** _____ **Teacher** _____

****

TO BE COMPLETED BY DENTIST

Date of Last Examination: _____

Check work that was completed at the last examination:

☐ **Inspection** ☐ **Cleaning** ☐ **Repair** ☐ **No Treatment Needed**

Please provide any comments about the child's dental health that the school nurse should be aware of:

_____

_____

_____

_____

_____

_____

_____

_____

Name of Dentist (please print): _____ **Phone:** _____

Dentist Signature: _____ **Date:** _____

Dentist Stamp Required

HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue
Harrison, New York 10528
(914) 835-3300

HEALTH REFERENCE SHEET

ILLNESS

Please consult with your doctor for evaluation, diagnosis and treatment if illness is suspected. Students should be fever free (without medication to control fever) and without vomiting or diarrhea for twenty-four hours before returning to school. It is important for to let your school nurse know if your child has been recently diagnosed with a communicable illness, such as Strep throat, Conjunctivitis (Pink Eye), Flu or Fifth Disease. Students with rashes and skin lesions can be excluded from school pending diagnosis and a written statement from the doctor is required upon return to school. Students who are absent for a period of more than two weeks are required to present a doctor's statement regarding the nature of illness and any necessary modifications in the school program.

INTERNAL MEDICATIONS

To ensure the safety of students and to comply with applicable regulations associated with the administration of medications to students in the school setting please note the following information. All medications, including over-the-counter (Tylenol, Advil, Benadryl, etc.) are administered only with written parental permission and written physician's orders. Parents/Guardians must provide the medication as ordered in a clearly labeled bottle. All medications must be dropped off to or picked up from the Health Office by an adult. If a medication is considered a controlled substance, the medication must be counted and signed for by both the school nurse and the adult providing the medication. Medications on field trips are managed according to district procedure.

HEALTH SCREENINGS-VISION, HEARING, SCOLIOSIS

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing health screenings as mandated by the State of New York. Parents/Guardians are notified if the results of the screening require further evaluation.

PHYSICAL EDUCATION-MODIFIED ACTIVITY/EXCUSE

A note from a parent or guardian will excuse a student from Physical Education and/or related physical activities for no more than two consecutive classes. A physician's note may be requested for repeated absence from Physical Education and related activities at the discretion of the school physician. If a student is excused from physical activities following treatment by a physician, a note is required from that physician to resume physical activities. Any student that sustains a concussion must be managed in accordance with the *HCSD Concussion Management Protocol.*