REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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: ___________________________ Affirmed Name (if applicable): ___________________________ DOB: ___________________________

Sex Assigned at Birth: ☐ Female ☐ Male Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X

School: ___________________________ Grade: ___________________________ Exam Date: ___________________________

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ Allergies

Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

☐ Asthma

☐ Intermittent ☐ Persistent ☐ Other:

☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached

☐ Seizures

Type: ☐ Medication/Treatment Order Attached

Date of last seizure: ☐ Seizure Care Plan Attached

☐ Diabetes

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: ☐ Yes ☐ Not Done Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: ___________________________ Weight: ___________________________ BP: ___________________________ Pulse: ___________________________ Respirations: ___________________________

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Lead Level Required for PreK &amp; K</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>☐ Test Done</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>☐ Lead Elevated &gt; 5 µg/dL</td>
<td></td>
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</tbody>
</table>

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

☐ HEENT ☐ Lymph nodes ☐ Abdomen ☐ Extremities ☐ Speech

☐ Dental ☐ Cardiovascular ☐ Back/Spine/Neck ☐ Skin ☐ Social Emotional

☐ Mental Health ☐ 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

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Name: 

Affirmed Name (if applicable): 

DOB: 

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

<table>
<thead>
<tr>
<th>Vision Screening</th>
<th>With Correction</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>☐ Yes ☐ No</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>☐ Yes ☐ No</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐</td>
</tr>
<tr>
<td>Color Perception</td>
<td>☐ Pass ☐ Fail</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes

Hearing Screening: 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.

<table>
<thead>
<tr>
<th>Pure Tone Screening</th>
<th>Right ☐ Pass ☐ Fail</th>
<th>Left ☐ Pass ☐ Fail</th>
<th>Referral ☐ Yes ☐</th>
<th>Not Done</th>
</tr>
</thead>
</table>

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7

<table>
<thead>
<tr>
<th></th>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐ Yes</td>
<td>☐</td>
</tr>
</tbody>
</table>

FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK

☐ *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ Student may participate in all activities without restrictions.

If Restrictions Apply – Complete the information below

☐ 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.
  ☐ 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

☐ Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE

☐ Confirmed free of communicable disease during exam

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: (please print)

Provider Address:

Phone: Fax:

Please Return This Form to Your Child’s School Health Office When Completed.