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	□ Medi	ledication/Treatment Order Attached							
☐ Yes, indicate typ	e 🗆 Food	□ Insects	□ La	tex 🗆 Medicat	tion Environmental				
Asthma □ No	□ Medi	cation/Treati	ment Ord	er Attached	ed Asthma Care Plan Attached				
☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other :									
Seizures □ No	Seizures □ No □ Medication/Treatment Order Attached □ Seizure Care Plan Attached								
☐ Yes, indicate type ☐ Type:									
Diabetes □ No							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. BMIkg/m2 Percentile (Weight Status Category): □ <5 th □ 5 th -49 th □ 50 th -84 th □ 85 th -94 th □ 95 th -98 th □ 99 th and>									
					49 □ 50	···-84··· ⊔ 85···-94	Ц 95	-98 Ц 99 and>	
Hyperlipidemia:	No ∐Y€	es I	Hypertensi	ion: □ No □ Yes					
PHYSICAL EXAMINATION/ASSESSMENT									
Height:	Weight:		BP:	: Pulse:		Respirations:			
TESTS	Positive	Negative	Date		Other Perti	inent Medical Concerns			
PPD/ PRN				_	-	Kidney \square Testicle			
Sickle Cell Screen/PRI			_		t Occurrence:				
Lead Level Required Grades Pre- K & K			Date	Mental Health:					
☐ Test Done ☐ Le			-1	Other:					
☐ System Review and Exam Entirely Normal Check Any Assessment Boxes <i>Outside</i> Normal Limits And Note Below Under Abnormalities									
			1		I .	I			
	, ,		☐ Abdomen		☐ Extremi		☐ Speech		
			☐ Back/Spine		☐ Skin		☐ Social Emotional		
			☐ Genitourinary		☐ Neurolo	gical	☐ Musculoskeletal		
☐ Assessment/Abnormalities Noted/Recommendations:					Diagnoses/Problems (list) ICD-10 Code				
☐ Additional Information Attached									

Name:	DOB:									
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 Inte	erscholastic Sport	s Categories (below) for Restrictions or modifications						
☐ No Contact Sports	Includes: ba	seball, basketbal	l, competitive cheer	leading, 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 :										
☐ Accommodations: Use additional space below to explain										
☐ Brace*/Orthotic	□ C	olostomy Applia	☐ Hearing Aids							
☐ Insulin Pump/Insulin Sen	sor* Medical/Prosthetic Device*			\square Pacemaker/Defibrillator*						
☐ Protective Equipment	□ S _I	oort Safety Gogg	\square 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									
List medications taken at home:										
	-									
IMMUNIZATIONS										
☐ Record Attached	☐ Rer	orted in NYSIIS		eived Today:						
necord / teached	·	ALTH CARE PR		nerved reday: — res — re						
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.										