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: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ 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:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **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

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

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

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

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.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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.
- ☐ **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

☐ **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	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ 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.

GREAT NECK PUBLIC SCHOOLS
Health Services
Immunization Record

NAME_____DOB_____SCHOOL_____

ADDRESS_____PHONE_____GRADE_____TEACHER_____

Under section 2164 of the New York State Public Health Law, all children attending school,… or any preschool program must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, Varicella, Meningococcal, Haemophilus Influenza b & Prevnar. Children who attend a preschool…must also show evidence of lead screening.
Please have your Health Care Provider fill in **Month, Day & Year of ALL Immunizations. ALL DATES ARE REQUIRED**.

Your child <u>may not</u> attend school without this information.

*****PLEASE CHECK WITH YOUR DOCTOR FOR THE REQUIRED DOSES FOR YOUR CHILD ACCORDING TO ACIP GUIDELINES*****

- **DTaP** → **<u>3-5 Doses Required</u>** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____
- **Tdap**→ **<u>1 Dose Required</u>** {Mandatory Grades 6th -12th} **AND ALSO**{Depending on Age & Grade}
  1. ____/____/____
- **IPV** → **<u>3-5 Doses Required</u>** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____
- **HBV (HEPATITIS B)**→ **<u>3 Doses Required</u>**
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ Additional Doses: ____/____/____ ____/____/____ ____/____/____
- **MMR**→ **<u>2 Doses Required</u>** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kindergarten.}

  MMR: 1. ____/____/____ 2. ____/____/____

  Or MEASLES: MUMPS RUBELLA
  1.____/____/____ 2. ____/____/____ 1. ____/____/____ 2.____/____/____ 1. ____/____/____ 2.____/____/____
- **VARICELLA VACCINE (CHICKEN POX)**→ **<u>2 Doses Required</u>** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kind., 1st & 2nd Grade}
  1. ____/____/____ 2. ____/____/____ <u>Or proof of Disease from Health Care Provider</u>→ DATE: 1. ____/____/____
- **MENINGOCOCCAL VACCINE**→ **<u>2 Doses Required</u>** {1st Dose Required for 7th Grade. 2nd Dose Required on or After Age 16, &/Or Entering 12th Grade.}
  1. ____/____/____ 2. ____/____/____

<u>For children entering Preschool program</u>

- **Hib (HAEMOPHILUS INFLUENZA b)**→ **<u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____
- **PREVNAR (PCV)** → **<u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____
- **LEAD SCREENING** →**<u>Required for Preschool</u>** → **____/____/____** → **_____**

<u>Optional Vaccines</u>

- **HEPATITIS A Vaccine (HAV)**→ 1. ____/____/____ 2. ____/____/____
- **HUMAN PAPILLOMAVIRUS (HPV)**→ 1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____
- **PPV (Pneumococcal Polysaccharide Vaccine)** → 1. ____/____/____ 2. ____/____/____
- **ROTATEQ**→ 1. ____/____/____ 2. ____/____/____ 3. ____/____/____
- **OTHER VACCINES: _____**→ 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

➢ PPD/TB TEST→ ____/____/____ Read ____/____/____ → _____ mm → Result: N___ P___

Children who have not been immunized may be admitted <u>with 1 Dose of **each required vaccine series</u> & has **WRITTEN** age appropriate appointments to complete the series according to the ACIP guidelines.**

<u>PHYSICIAN'S SIGNATURE</u>, **<u>STAMP</u>**, ADDRESS, PHONE NUMBER

_____

DATE: ____/____/____ _____

_____