**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**
**TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**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:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| ☐ **Asthma** | ☐ Intermittent ☐ Persistent ☐ Other:<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| ☐ **Seizures** | Type: Date of last seizure:<br>☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| ☐ **Diabetes** | Type: ☐ 1 ☐ 2<br>☐ 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** | **With Correction** ☐ Yes ☐ No | **Right** | **Left** | **Referral** | **Not Done** |
|---|---|---|---|---|---|
| Distance Acuity | | 20/ | 20/ | ☐ Yes | ☐ |
| Near Vision Acuity | | 20/ | 20/ | | ☐ |
| Color Perception Screening | ☐ Pass ☐ Fail | | | | ☐ |

Notes

| **Hearing** 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 Dominic 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*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*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.**