

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			Date	
☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$				
☐ System Review and Abnormal Findings Listed Below				
☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ 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:				DOB:	
SCREENINGS					
Vision (w/correction if prescribed)	Right	Left	Referral	Not Done	
Distance Acuity	20/	20/	☐ Yes ☐ No	☐	
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 ☐ No	☐	
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7				Not Done	
	Negative ☐	Positive ☐	Referral ☐ Yes ☐ No	☐	
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK					
☐ Student may participate in all activities without restrictions. ☐ 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 <u>ONLY</u> 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 Age of First Menses (if applicable) : _____					
☐ Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
MEDICATIONS					
☐ Order Form for Medication(s) Needed at School Attached					
IMMUNIZATIONS					
☐ Record Attached ☐ Reported in NYSIIS					
HEALTH CARE PROVIDER					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form To Your Child's School When Completed.					