

Miller Place Union Free School District Health Examination Form

**Miller Place
High School**

15 Memorial Drive
Miller Place, NY 11764
Health Office: 631-474-2481
Fax: 631-331-4093

**North Country Road
Middle School**

191 North Country Rd
Miller Place, NY 11764
Health Office: 631-474-7258
Fax: 631-474-0362

**Laddie A. Decker
Sound Beach School**

197 North Country Rd
Miller Place, NY 11764
Health Office: 631-474-2721
Fax: 631-331-4342

**Andrew Muller
Primary School**

65 Lower Rocky Point Road
Miller Place, NY 11764
Health Office: 631-474-2717
Fax: 631-474-4738

Dear Parents/Guardians,

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade.**

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K, 1st, 3rd, 5th, 7th, 9th, & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.

We suggest you make copies of the completed forms for your own records before sending them to the school health office.

Sincerely,
The Miller Place School Nurses

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:	
	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ Asthma	Type: ☐ 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 Type: ☐ 2	
	☐ Medication/Treatment Ordered Attached	☐ Diabetes Medical Management Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History 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 ☐ No ☐ 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
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 New Entrants, 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/	☐ Yes	☐
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 Required for Boys grade 9 and Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐	☐
Notes:					
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
☐ Family cardiac history reviewed – required for sports (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, or Wrestling.					
☐ Limited Contact Sports: Baseball, Fencing, Softball, or Volleyball					
☐ Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.					
☐ Other Restrictions:					
☐ Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the 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: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					