

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 ☐ Yes, indicate type	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental	

Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
	☐ Intermittent ☐ Persistent ☐ Other : _____	

Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
	☐ Type: _____	Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached	☐ Diabetes Medical Mgmt. Plan Attached
	☐ 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.

BMI _____ kg/m2 Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and >

Hypertension: ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle ☐ Concussion – Last Occurrence: _____ ☐ Mental Health: _____ ☐ Other: _____
Sickle Cell Screen/PRN	☐	☐		
Lead Level Required Grades Pre- K & K		Date		
☐ Test Done ☐ Lead Elevated ≥ 10 μ g/dL				

☐ System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

☐ 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

Name:			DOB:	
SCREENINGS				
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 And girls grades 5 & 7	Negative	Positive	Referral	
	☐	☐	☐ 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 Interscholastic Sports Categories (below) for Restrictions or modifications				
☐ No Contact Sports Includes: baseball, basketball, competitive cheerleading, 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: ☐ I ☐ II ☐ III ☐ IV ☐ V				
☐ Accommodations: Use additional space below to explain				
☐ Brace*/Orthotic ☐ Colostomy Appliance* ☐ Hearing Aids				
☐ Insulin Pump/Insulin Sensor* ☐ Medical/Prosthetic Device* ☐ Pacemaker/Defibrillator*				
☐ Protective Equipment ☐ Sport Safety Goggles ☐ 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 attached				
List medications taken at home:				
IMMUNIZATIONS				
☐ Record Attached		☐ Reported in NYSIIS		Received Today: ☐ Yes ☐ No
HEALTH CARE PROVIDER				
Medical Provider Signature:				Date:
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				