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	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 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: *(please print)*

Provider Address:

Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.