

| <b>REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM</b><br><b>TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR</b><br><b>IF AN AREA IS NOT ASSESSED, INDICATE NOT DONE</b>                                                                                                                                                                                                     |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------|
| <b>Note:</b> 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).                                                                                             |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| <b>STUDENT INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| Name:                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                 | Affirmed Name (if applicable):                                                                                                               |                                                                              | DOB:                                                                                |            |
| Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male                                                                                                                                                                                                                                                                                                               |                                                                                                                 | Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X |                                                                              |                                                                                     |            |
| School:                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                 |                                                                                                                                              | Grade:                                                                       |                                                                                     | Exam Date: |
| <b>HEALTH HISTORY</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| If yes to any diagnoses below, check all that apply and provide additional information.                                                                                                                                                                                                                                                                                                            |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| <input type="checkbox"/> <b>Allergies</b>                                                                                                                                                                                                                                                                                                                                                          | Type:                                                                                                           |                                                                                                                                              |                                                                              |                                                                                     |            |
|                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Medication/Treatment Order Attached                                                    |                                                                                                                                              | <input type="checkbox"/> Anaphylaxis Care Plan Attached                      |                                                                                     |            |
| <input type="checkbox"/> <b>Asthma</b>                                                                                                                                                                                                                                                                                                                                                             | Type: <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: |                                                                                                                                              |                                                                              |                                                                                     |            |
|                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Medication/Treatment Order Attached                                                    |                                                                                                                                              | <input type="checkbox"/> Asthma Care Plan Attached                           |                                                                                     |            |
| <input type="checkbox"/> <b>Seizures</b>                                                                                                                                                                                                                                                                                                                                                           | Type:                                                                                                           |                                                                                                                                              | <input type="checkbox"/> Date of Last Seizure:                               |                                                                                     |            |
|                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Medication/Treatment Order Attached                                                    |                                                                                                                                              | <input type="checkbox"/> Seizure Care Plan Attached                          |                                                                                     |            |
| <input type="checkbox"/> <b>Diabetes</b>                                                                                                                                                                                                                                                                                                                                                           | Type: <input type="checkbox"/> 1 Type: <input type="checkbox"/> 2                                               |                                                                                                                                              |                                                                              |                                                                                     |            |
|                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Medication/Treatment Ordered Attached                                                  |                                                                                                                                              | <input type="checkbox"/> Diabetes Medical Management Plan Attached           |                                                                                     |            |
| <b>Risk Factors for Diabetes or Pre-Diabetes:</b> 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<br>Percentile (Weight Status Category) <input type="checkbox"/> <5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> - 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> - 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> - 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> -98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and > |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| Hyperlipidemia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done                                                                                                                                                                                                                                                                                         |                                                                                                                 |                                                                                                                                              | Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> Not Done |                                                                                     |            |
| <b>PHYSICAL EXAMINATION/ASSESSMENT</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| Height:                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                 | Weight:                                                                                                                                      |                                                                              | BP:                                                                                 |            |
|                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                 |                                                                                                                                              |                                                                              | Pulse:                                                                              |            |
|                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                 |                                                                                                                                              |                                                                              | Respirations:                                                                       |            |
| <b>Laboratory Testing</b>                                                                                                                                                                                                                                                                                                                                                                          | <b>Positive</b>                                                                                                 | <b>Negative</b>                                                                                                                              | <b>Date</b>                                                                  | <b>Lead Level</b><br>Required for PreK & K                                          |            |
| TB-PRN                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/>                                                                                        | <input type="checkbox"/>                                                                                                                     |                                                                              | <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 µg/dL |            |
| Sickle Cell Screen-PRN                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/>                                                                                        | <input type="checkbox"/>                                                                                                                     |                                                                              |                                                                                     |            |
| <input type="checkbox"/> <b>System Review Within Normal Limits</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| <input type="checkbox"/> <b>Abnormal Findings–List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)</b>                                                                                                                                                                                                                                             |                                                                                                                 |                                                                                                                                              |                                                                              |                                                                                     |            |
| <input type="checkbox"/> HEENT                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Lymph nodes                                                                            | <input type="checkbox"/> Abdomen                                                                                                             | <input type="checkbox"/> Extremities                                         | <input type="checkbox"/> Speech                                                     |            |
| <input type="checkbox"/> Dental                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Cardiovascular                                                                         | <input type="checkbox"/> Back/Spine/Neck                                                                                                     | <input type="checkbox"/> Skin                                                | <input type="checkbox"/> Social Emotional                                           |            |
| <input type="checkbox"/> Mental Health                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Lungs                                                                                  | <input type="checkbox"/> Genitourinary                                                                                                       | <input type="checkbox"/> Neurological                                        | <input type="checkbox"/> Musculoskeletal                                            |            |
| <input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:                                                                                                                                                                                                                                                                                                                           |                                                                                                                 |                                                                                                                                              | Diagnoses/Problems (list): ICD-10 Code*                                      |                                                                                     |            |
| <input type="checkbox"/> Additional Information Attached                                                                                                                                                                                                                                                                                                                                           |                                                                                                                 |                                                                                                                                              | *Required only for students with an IEP receiving Medicaid                   |                                                                                     |            |

|                                                                                                                                                                                                |                                                                                 |                                                                         |                                                                                      |                              |                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------|--------------------------|
| Name:                                                                                                                                                                                          |                                                                                 | Affirmed Name (if applicable):                                          |                                                                                      | DOB:                         |                          |
| <b>SCREENINGS</b>                                                                                                                                                                              |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Vision & Hearing Screenings Required for New Entrants, PreK or K, 1, 3, 5, 7, & 11                                                                                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Vision</b>                                                                                                                                                                                  | <b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Right</b>                                                            | <b>Left</b>                                                                          | <b>Referral</b>              | <b>Not Done</b>          |
| Distance Acuity                                                                                                                                                                                |                                                                                 | 20/                                                                     | 20/                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| Near Vision Acuity                                                                                                                                                                             |                                                                                 | 20/                                                                     | 20/                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail                                                                                                         |                                                                                 |                                                                         |                                                                                      |                              | <input type="checkbox"/> |
| Notes:                                                                                                                                                                                         |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz;<br>for grades 7 & 11 also test at 6000 & 8000 Hz.                                   |                                                                                 |                                                                         |                                                                                      |                              | <b>Not Done</b>          |
| Pure Tone Screening                                                                                                                                                                            | <b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail        | <b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail | <b>Referral</b> <input type="checkbox"/> Yes                                         |                              | <input type="checkbox"/> |
| Notes:                                                                                                                                                                                         |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>Scoliosis Screening Required</b> for Boys grade 9 and<br>Girls grades 5 & 7                                                                                                                 |                                                                                 | <b>Negative</b>                                                         | <b>Positive</b>                                                                      | <b>Referral</b>              | <b>Not Done</b>          |
|                                                                                                                                                                                                |                                                                                 | <input type="checkbox"/>                                                | <input type="checkbox"/>                                                             | <input type="checkbox"/>     | <input type="checkbox"/> |
| Notes:                                                                                                                                                                                         |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK</b>                                                                                                                         |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Family cardiac history reviewed</b> – required for sports (Dominic Murray Sudden Cardiac Arrest Prevention Act)                                                    |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>                                                                                                |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>If Restrictions Apply</b> , complete the information below.                                                                                                                                 |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Student is restricted from participation in:</b>                                                                                                                   |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, or Wrestling. |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, or Volleyball                                                                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Other Restrictions:</b>                                                                                                                                            |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Other Accommodations*:</b> (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.                                                          |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>MEDICATIONS</b>                                                                                                                                                                             |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <input type="checkbox"/> Order Form for medication(s) needed at school attached                                                                                                                |                                                                                 |                                                                         |                                                                                      |                              |                          |
| <b>COMMUNICABLE DISEASE</b>                                                                                                                                                                    |                                                                                 |                                                                         | <b>IMMUNIZATIONS</b>                                                                 |                              |                          |
| <input type="checkbox"/> Confirmed free of communicable disease during exam                                                                                                                    |                                                                                 |                                                                         | <input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS |                              |                          |
| <b>HEALTHCARE PROVIDER</b>                                                                                                                                                                     |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Healthcare Provider Signature:                                                                                                                                                                 |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Provider Name: <i>(please print)</i>                                                                                                                                                           |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Provider Address:                                                                                                                                                                              |                                                                                 |                                                                         |                                                                                      |                              |                          |
| Phone:                                                                                                                                                                                         |                                                                                 |                                                                         | Fax:                                                                                 |                              |                          |
| <b>Please Return This Form to Your Child's School Health Office When Completed.</b>                                                                                                            |                                                                                 |                                                                         |                                                                                      |                              |                          |