North Merrick Union Free School District

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED INENTIRETY BY PRIVATEHEALTH CAREPROVIDEROR 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 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐

Yes, indicate type ☐Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____ **Risk Factorsfor 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.

Hyperlipidemia: ☐ No ☐ Yes **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 µg/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: □ Additional Information Attached	Diagnoses/Problems (list) ICD-10 Code _____ _____ _____ _____ _____ _____ _____ _____

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	**Negative**	**Positive**	**Referral**	

And girls grades 5 & 7	□	□	□ 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) Neededat 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: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.