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| **REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**  **TO BE COMPLETED BY PRIVATE HEALTHCARE 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: | | | | | 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** | | * Intermittent ☐ Persistent ☐ Other: * Medication/Treatment Order Attached ☐ Asthma Care Plan Attached | | | | | | | | |
| ☐ **Seizures** | | Type:   * Medication/Treatment Order Attached | | | | | Date of last seizure:   * Seizure Care Plan Attached | | | |
| ☐ **Diabetes** | | Type: ☐ 1 ☐ 2   * Medication/Treatment Order Attached | | | | | * Diabetes Medical Mgmt. Plan Attached | | | |
| **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):**  < 5**th**  5th- 49th  50th- 84th  85th- 94th  95th- 98th  99th and >  **Hyperlipidemia:** ☐ Yes ☐ 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 | | | |

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| Name: | | | | | | | Affirmed Name (if applicable): | | | | | | DOB: |
| **SCREENINGS** | | | | | | | | | | | | | |
| Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11 | | | | | | | | | | | | | |
| **Vision Screening** | **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 Screening:** 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**: Boys grade 9, Girls grades 5 & 7 | | | | | | **Negative** | | | | **Positive** | | **Referral** | **Not Done** |
| ☐ | | | | ☐ | | * Yes | ☐ |
| **FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS\*/PLAYGROUND/WORK** | | | | | | | | | | | | | |
| * **\*Family cardiac history reviewed –** required for 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, and Wrestling. | | | | | | | | | | | | | |
| * **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball. * **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. * **Other Restrictions:** | | | | | | | | | | | | | |
| **Developmental Stage for Athletic Placement Process ONLY required** for students in Grades 7 & 8 who wish to play at the  high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.  **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V | | | | | | | | | | | | | |
| * **Other Accommodations\*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):     \*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.** | | | | | | | | | | | | | |