STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2 4, 7 & 10
Interscholastic sports and working papers

****YOU WILL BE REQUIRED TO SUBMIT THIS FORM WITHIN 30 DAYS OF YOUR CHILD'S ENROLLMENT OR ENTRY INTO THEIR RESPECTIVE GRADE IF YOU FAIL TO DO SO, YOU WILL RECEIVE A NOTICE REQUIRING YOU TO SUBMIT THIS FORM. IF YOU FAIL TO RESPOND TO SUCH NOTICE WITHIN 30 DAYS, THE DISTRICT'S DIRECTOR OF HEALTH SERVICES SHALL PERFORM YOUR CHILD'S MEDICAL EXAMINATION**

Name ______________________ DOB ______________ Gender ☐ M ☐ F

School ______________________ Grade ______ ☐ No Grade Exam Date ______

IMMUNIZATIONS

☐ Immunization record attached | ☐ Immunizations received today

☐ Immunizations reported on NYSIIS ______________________

☐ No immunizations received today | ☐ Will return on ______ to receive ______

HEALTH HISTORY

☐ **Asthma:** ☐ Intermittent ☐ Persistent ☐ Asthma Action Plan Attached

☐ **Diabetes:** ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension ☐ Diabetes Medical Mgmt Plan Attached

☐ **Seizures** Type ______________ Last Occurrence ______ ☐ Emergency Care Plan Attached

☐ **Allergies** ☐ Non Life Threatening ☐ Life Threatening ☐ Emergency Care Plan Attached

Type ☐ Food ☐ Insect ☐ Latex ☐ Medication ☐ Seasonal/Environmental ☐ Other ______________

Allergen(s) ______________________________

☐ Hx of Anaphylaxis Last occurrence ______________ Previous symptoms ______________

Treatment prescribed ☐ None ☐ Antihistimine ☐ Epinephrine Autoinjector

Significant Medical/Surgical Information	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead	☐	☐	☐	

☐ Vision one eye only ☐ One functioning kidney ☐ One testicle ☐ Concussion – Last occurrence ______

PHYSICAL EXAMINATION

Height. ______ **Weight** ______ BP ______ **Pulse** ______ **Respirations.** ______

Scoliosis: ☐ Negative ☐ Positive

Degree of deviation ______________

Angle of trunk rotation via scoliometer ______

Weight Status Category (BMI Percentile)

☐ < 5th ☐ 85th – 94th
☐ 5th – 49th ☐ 95th – 98th
☐ 50th – 84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐ Yes ☐ No
Distance acuity with lenses			☐ Yes ☐ No
Vision near vision			☐ Yes ☐ No
Vision – color perception	☐ Pass	☐ Fail	☐ Yes ☐ No
Hearing	**Right**	**Left**	**Referral**
☐ 20 db sweep screen both ears or			☐ Yes ☐ No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders) **Tanner** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities

Name ______________________________ DOB ______________

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories

- ☐ **No Contact Sports** Includes basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** Includes archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, Track & field, fencing, badminton
- ☐ **Other Specific Restrictions:**

Accommodations / Protective Equipment:	☐ Athletic Cup	☐ Insulin Pump / Insulin Sensor	☐ Pacemaker
	☐ Brace / Orthotic	☐ Medical / Prosthetic Device	☐ Sports Safety Goggles
	☐ Hearing Aides	☐ Other	

MEDICATION HISTORY (optional)
Please list names of prescribed or OTC medications used on a routine basis at home

______________________ ______________________
______________________ ______________________
______________________ ______________________

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS – VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools

☐ **Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan, or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications I will provide the medication in the original pharmacy or over the counter container This plan will be shared with staff caring for my child

Parent/Guardian Signature ______________________________

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature ______________________ Date ______________

Provider Name (please print) ______________________ Phone # (   ) ______________

Provider Address ______________________ Fax # (   ) ______________

Return to:

School Nurse ______________________ School ______________

Phone # (   ) ____________ Fax (   ) ____________ Date ______________