

BETHPAGE SCHOOL DISTRICT

CHERRY AND STEWART AVENUES, BETHPAGE, NEW YORK 11714

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY 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, 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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

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): <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes Hypertension: No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion -- Last Occurrence: _____
Lead Level Required Grades Pre-K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10 \mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<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
	_____	_____
	_____	_____
	_____	_____

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Name:	DOB:
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SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> 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) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

- Record Attached Reported in NYSIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

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