

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: <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: |

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

| | |
|---|--|
| <input type="checkbox"/> Allergies | Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached |
| <input type="checkbox"/> Asthma | <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"/> Seizures | Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached |
| <input type="checkbox"/> Diabetes | Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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): < 5th 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 |
| TB- PRN | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$ |
| Sickle Cell Screen-PRN | <input type="checkbox"/> | <input type="checkbox"/> | | |

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

| | | | | |
|--|---|--|---------------------------------------|---|
| <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* |
|--|---|

Additional Information Attached

*Required only for students with an IEP receiving Medicaid

| | | |
|-------|--------------------------------|------|
| Name: | Affirmed Name (if applicable): | DOB: |
|-------|--------------------------------|------|

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

| Vision Screening | With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No | Right | Left | Referral | Not Done |
|----------------------------|--|-------|------|------------------------------|--------------------------|
| 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

| | |
|--|-----------------|
| 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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail | Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail | Referral <input type="checkbox"/> Yes | <input type="checkbox"/> |
|---------------------|---|--|---------------------------------------|--------------------------|

Notes

| | | | | |
|---|--------------------------|--------------------------|------------------------------|--------------------------|
| Scoliosis Screening: Boys grade 9, Girls grades 5 & 7 | Negative | Positive | Referral | Not Done |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> |

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

Confirmed free of communicable disease during exam

IMMUNIZATIONS

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.