

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* |
| <input type="checkbox"/> 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 | | | | | | |
| <input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act | | | | | | |
| <input type="checkbox"/> Student may participate in all activities without restrictions. | | | | | | |
| If Restrictions Apply – Complete the information below | | | | | | |
| <input type="checkbox"/> Student is restricted from participation in: | | | | | | |
| <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. | | | | | | |
| <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. | | | | | | |
| <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. | | | | | | |
| <input type="checkbox"/> Other Restrictions: | | | | | | |
| Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V | | | | | | |
| <input type="checkbox"/> 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 | | | | | | |
| <input type="checkbox"/> Order Form for medication(s) needed at school attached | | | | | | |
| COMMUNICABLE DISEASE | | | IMMUNIZATIONS | | | |
| <input type="checkbox"/> Confirmed free of communicable disease during exam | | | <input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS | | | |
| HEALTHCARE PROVIDER | | | | | | |
| Healthcare Provider Signature: | | | | | | |
| Provider Name: <i>(please print)</i> | | | | | | |
| Provider Address: | | | | | | |
| Phone: | | | Fax: | | | |
| Please Return This Form to Your Child's School Health Office When Completed. | | | | | | |