

# 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:<br><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:<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached |
| <input type="checkbox"/> Seizures  | Type: _____ Date of last seizure: _____<br><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<br><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/m<sup>2</sup>

**Percentile (Weight Status Category):**  < 5<sup>th</sup>  5<sup>th</sup>- 49<sup>th</sup>  50<sup>th</sup>- 84<sup>th</sup>  85<sup>th</sup>- 94<sup>th</sup>  95<sup>th</sup>- 98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  Yes  Not Done      **Hypertension:**  Yes  Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

|                           |                          |                          |               |  |
|---------------------------|--------------------------|--------------------------|---------------|--|
| <b>Height:</b>            | <b>Weight:</b>           | <b>BP:</b>               | <b>Pulse:</b> | <b>Respirations:</b>   |
| <b>Laboratory Testing</b> | <b>Positive</b>          | <b>Negative</b>          | <b>Date</b>   | <b>Lead Level</b><br>Required for PreK & K   |
| TB- PRN                   | <input type="checkbox"/> | <input type="checkbox"/> |               | <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g}/\text{dL}$ |
| 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:                         |                          |
| <b>SCREENINGS</b>   |   |   |  |                              |                          |
| Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11  |   |   |  |                              |                          |
| <b>Vision Screening</b>   | <b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Right</b>  | <b>Left</b>  | <b>Referral</b>              | <b>Not Done</b>          |
| 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   |   |   |  |                              |                          |
| <b>Hearing Screening:</b> 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.  |   |   |  |                              | <b>Not Done</b>          |
| Pure Tone Screening   | <b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail        | <b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail | <b>Referral</b> <input type="checkbox"/> Yes   |                              | <input type="checkbox"/> |
| Notes   |   |   |  |                              |                          |
| <b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7  |   | <b>Negative</b>   | <b>Positive</b>  | <b>Referral</b>              | <b>Not Done</b>          |
|   |   | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| <b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>   |   |   |  |                              |                          |
| <input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act  |   |   |  |                              |                          |
| <input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>   |   |   |  |                              |                          |
| <b>If Restrictions Apply</b> – Complete the information below   |   |   |  |                              |                          |
| <input type="checkbox"/> <b>Student is restricted from participation in:</b>  |   |   |  |                              |                          |
| <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.   |   |   |  |                              |                          |
| <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.  |   |   |  |                              |                          |
| <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.   |   |   |  |                              |                          |
| <input type="checkbox"/> <b>Other Restrictions:</b>   |   |   |  |                              |                          |
| <b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. |   |   |  |                              |                          |
| <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V   |   |   |  |                              |                          |
| <input type="checkbox"/> <b>Other Accommodations*:</b> 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.   |   |   |  |                              |                          |
| <b>MEDICATIONS</b>  |   |   |  |                              |                          |
| <input type="checkbox"/> Order Form for medication(s) needed at school attached   |   |   |  |                              |                          |
| <b>COMMUNICABLE DISEASE</b>   |   |   | <b>IMMUNIZATIONS</b>   |                              |                          |
| <input type="checkbox"/> Confirmed free of communicable disease during exam   |   |   | <input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS |                              |                          |
| <b>HEALTHCARE PROVIDER</b>  |   |   |  |                              |                          |
| Healthcare Provider Signature:  |   |   |  |                              |                          |
| Provider Name: <i>(please print)</i>  |   |   |  |                              |                          |
| Provider Address:   |   |   |  |                              |                          |
| Phone:  |   |   | Fax:   |                              |                          |
| <b>Please Return This Form to Your Child's School Health Office When Completed.</b>   |   |   |  |                              |                          |