

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR IF AN AREA IS NOT ASSESSED INDICATE NOT DONE					
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: ☐ M ☐ F	
School:				DOB:	
				Grade:	
				Exam Date:	
HEALTH HISTORY					
Allergies ☐ No ☐ Yes, indicate type		Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached			
Asthma ☐ No ☐ Yes, indicate type		☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached			
Seizures ☐ No ☐ Yes, indicate type		Type: ☐ Medication/Treatment Order Attached		Date of last seizure: ☐ Seizure Care Plan Attached	
Diabetes ☐ No ☐ Yes, indicate type		Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached			
Risk Factors for Diabetes or Pre-Diabetes: <i>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.</i>					
BMI _____ kg/m2					
Percentile (Weight Status Category): ☐ <5 th ☐ 5 th -49 th ☐ 50 th -84 th ☐ 85 th -94 th ☐ 95 th -98 th ☐ 99 th and>					
Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done			Hypertension: ☐ No ☐ Yes ☐ Not Done		
PHYSICAL EXAMINATION/ASSESSMENT					
Height:		Weight:		BP:	
				Pulse:	
				Respirations:	
Laboratory Testing		Positive Negative		Date	
TB- PRN		☐		☐	
Sickle Cell Screen-PRN		☐		☐	
Lead Level Required Grades Pre- K & K			Date		
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL					
☐ System Review and Abnormal Findings Listed Below					
☐ HEENT		☐ Lymph nodes		☐ Abdomen	
☐ Dental		☐ Cardiovascular		☐ Extremities	
☐ Neck		☐ Lungs		☐ Skin	
		☐ Genitourinary		☐ Neurological	
				☐ Speech	
				☐ Social Emotional	
				☐ Musculoskeletal	
☐ Assessment/Abnormalities Noted/Recommendations:				Diagnoses/Problems (list) ICD-10 Code*	
☐ Additional Information Attached				*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
SCREENINGS					
Vision (w/correction if prescribed)	Right	Left	Referral	Not Done	
Distance Acuity	20/	20/	☐ Yes ☐ No	☐	
Near Vision Acuity	20/	20/		☐	
Color Perception Screening ☐ Pass ☐ Fail				☐	
Notes					
Hearing 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 ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail	Referral ☐ Yes ☐ No	☐	
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done	
	☐	☐	☐ Yes ☐ No	☐	
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK					
☐ Student may participate in all activities without restrictions. ☐ 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 <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: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____					
☐ Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
MEDICATIONS					
☐ Order Form for Medication(s) Needed at School Attached					
IMMUNIZATIONS					
☐ Record Attached ☐ Reported in NYSIIS					
HEALTH CARE PROVIDER					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form To Your Child's School When Completed.					