# 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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex:</th>
<th>M</th>
<th>F</th>
<th>DOB:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>School:</th>
<th>Grade:</th>
<th>Exam Date:</th>
</tr>
</thead>
</table>

## HEALTH HISTORY

### Allergies

- [ ] No
- [ ] Yes, indicate type: 
- [ ] Food
- [ ] Insects
- [ ] Latex
- [ ] Medication
- [ ] Environmental
- [ ] 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
- [ ] Seizure Care Plan Attached
- [ ] Date of last seizure: ________________

### Diabetes

- [ ] No
- [ ] Yes, indicate type:
- [ ] Type 1
- [ ] Type 2
- [ ] HbA1c results: ________________
- [ ] 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.

<table>
<thead>
<tr>
<th>BMI kg/m²</th>
<th>Percentile (Weight Status Category):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] &lt;5th  [ ] 5th-49th  [ ] 50th-84th  [ ] 85th-94th  [ ] 95th-98th  [ ] 99th+</td>
</tr>
</tbody>
</table>

### Hyperlipidemia

- [ ] No
- [ ] Yes

### Hypertension

- [ ] No
- [ ] Yes

## PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>TESTS</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD/PRN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Lead Level Required Grades Pre-K & K

<table>
<thead>
<tr>
<th>Date</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Test Done
- [ ] Lead Elevated > 10 μg/dL

### System Review and Exam Entirely Normal

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

- [ ] HEENT
- [ ] Lymph nodes
- [ ] Abdomen
- [ ] Extremities
- [ ] Speech
- [ ] Dental
- [ ] Cardiovascular
- [ ] Back/Spine
- [ ] Skin
- [ ] Social Emotional
- [ ] Neck
- [ ] Lungs
- [ ] Genitourinary
- [ ] Neurological
- [ ] Musculoskeletal
- [ ] Assessment/Abnormalities Noted/Recommendations:

<table>
<thead>
<tr>
<th>Diagnoses/Problems (list)</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
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- [ ] Additional Information Attached

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<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Color</td>
<td>□ Pass</td>
<td>□ Fail</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Right dB</th>
<th>Left dB</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scoliosis</th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Required for boys grade 9</strong></td>
<td>Negative</td>
<td>Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>And girls grades 5 &amp; 7</strong></td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Deviations 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
    - □ 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, Skating, 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
      - □ Brace*/Orthotic
      - □ Colostomy Appliance*
      - □ Hearing Aids
      - □ Insulin Pump/Insulin Sensor*
      - □ Medical/Prosthetic Device*
      - □ Pacemaker/Defibrillator*
      - □ Protective Equipment
      - □ Sport Safety Goggles
      - □ 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 NYSIIS Received Today: □ Yes □ No

**HEALTH CARE PROVIDER**

Medical Provider Signature: Date: 

Provider Name: (please print) Stamp:

Provider Address: 

Phone: 

Fax: 

Please Return This Form To Your Child’s School When Entirely Completed.