

STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: M F
 School: _____ Grade: No Grade Exam Date: _____

IMMUNIZATIONS

- Immunization record attached
 Immunizations reported on NYSIIS
 No immunizations received today
- Immunizations received today:
 Will return on: _____ to receive: _____

HEALTH HISTORY

- Asthma: Intermittent Persistent Asthma Action Plan Attached
 Diabetes: Type I Type 2 Hyperlipidemia Hypertension Diabetes Medical Mgmt Plan Attached
 Seizures Type: _____ Last Occurrence: _____ Emergency Care Plan Attached
 Allergies: Non Life-Threatening Life-Threatening Emergency Care Plan Attached

Type: Food Insect Latex Medication Seasonal/Environmental Other: _____

Allergen(s): _____

Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____

Treatment prescribed: None Antihistimine Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision one eye only One functioning kidney One testicle Concussion - Last occurrence: _____

PHYSICAL EXAMINATION

Height:	Weight:	BP:	Pulse:	Respirations:		
Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive		Vision		Right	Left	Referral
Degree of deviation: _____		Distance acuity				<input type="checkbox"/> Yes <input type="checkbox"/> No
Angle of trunk rotation via scoliometer: _____		Distance acuity with lenses				<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Status Category (BMI Percentile):		Vision - near vision				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <5 th	<input type="checkbox"/> 85 th - 94 th	Vision - color perception		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 5 th - 49 th	<input type="checkbox"/> 95 th - 98 th	Hearing		Right	Left	Referral
<input type="checkbox"/> 50 th - 84 th	<input type="checkbox"/> 99 th & higher	<input type="checkbox"/> 20 db sweep screen both ears or				<input type="checkbox"/> Yes <input type="checkbox"/> No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: I II III IV V

SYSTEM REVIEW AND EXAM ENTIRELY NORMAL Additional information attached

Specify any abnormalities: _____

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

- Full Activity** without restrictions including Physical Education and Athletics.
- Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.
 - No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
 - No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
 - Other Specific Restrictions:**

Accommodations / Protective Equipment:	<input type="checkbox"/> Athletic Cup	<input type="checkbox"/> Insulin Pump/Insulin Sensor	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Brace/Orthotic	<input type="checkbox"/> Medical /Prosthetic Device	<input type="checkbox"/> Sports Safety Goggles
	<input type="checkbox"/> Hearing Aides	<input type="checkbox"/> Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

- Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature: _____

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____	Date: _____
Provider Name: (please print) _____	Phone #: () _____
Provider Address: _____	Fax #: () _____

Return to:

School Nurse: _____	School: _____
Phone #: () _____	Fax: () _____
	Date: _____