

# 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: <input type="checkbox"/> Medication/Treatment Order Attached	Date of last seizure: <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/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

Height:	Weight:	BP:	Pulse:	Respirations:																
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">Laboratory Testing</th> <th style="width: 10%;">Positive</th> <th style="width: 10%;">Negative</th> <th style="width: 10%;">Date</th> </tr> <tr> <td>TB-PRN</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Sickle Cell Screen-PRN</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </table>			Laboratory Testing	Positive	Negative	Date	TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%;">Lead Level Required for PreK &amp; K</th> <th style="width: 40%;">Date</th> </tr> <tr> <td><input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 µg/dL</td> <td></td> </tr> </table>		Lead Level Required for PreK & K	Date	<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 µg/dL	
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☐ 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:  <input type="checkbox"/> Additional Information Attached	Diagnoses/Problems (list) <span style="float: right;">ICD-10 Code*</span>  <p style="font-size: small;">*Required only for students with an IEP receiving Medicaid</p>
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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>	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 <input type="checkbox"/>	Positive <input type="checkbox"/>	Referral <input type="checkbox"/> Yes	Not Done <input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>					
<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.					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<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>					
Developmental Stage for Athletic Placement Process <b>ONLY</b> required 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.					
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"/> <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: (please print)					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					