

**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 NYSIS  
 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:		
<b>Scoliosis:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive		<b>Vision</b>		<b>Right</b>	<b>Left</b>	<b>Referral</b>
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
<b>Weight Status Category (BMI Percentile):</b>		Vision - near vision				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <5 <sup>th</sup>	<input type="checkbox"/> 85 <sup>th</sup> - 94 <sup>th</sup>	Vision - color perception		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 5 <sup>th</sup> - 49 <sup>th</sup>	<input type="checkbox"/> 95 <sup>th</sup> - 98 <sup>th</sup>	<b>Hearing</b>		<b>Right</b>	<b>Left</b>	<b>Referral</b>
<input type="checkbox"/> 50 <sup>th</sup> - 84 <sup>th</sup>	<input type="checkbox"/> 99 <sup>th</sup> & 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:**

<b>Accommodations / Protective Equipment:</b>	<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: _____