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| **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** |
| Name: | Sex: M F | DOB: |
| School: | Grade: | Exam Date: |
| **HEALTH HISTORY** |
| **Allergies** ☐ NoYes, indicate type | * Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
* Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
 |

**Asthma** ☐ No

* Yes, indicate type
* Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
* Intermittent ☐ Persistent ☐ Other :

**Seizures** ☐ No

* Yes, indicate type
* Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
* Type: Date of last seizure:

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| **Diabetes** ☐ No* Yes, indicate type
 | * Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

☐Type 1 ☐ Type 2 ☐ HgbA1c results: Date Drawn:  |
| **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/m2 **Percentile (Weight Status Category):** <5**th** 5th-49th 50th-84th 85th-94th 95th-98th 99th and< |
| **Hyperlipidemia:** ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes |

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| **PHYSICAL EXAMINATION/ASSESSMENT** |
| **Height: Weight: BP: Pulse: Respirations:** |
| **TESTS** | **Positive** | **Negative** | **Date** | **Other Pertinent Medical Concerns** |
| PPD/ PRN | ☐ | ☐ |  | One Functioning: ☐ Eye ☐ Kidney ☐ Testicle* Concussion – Last Occurrence:
* Mental Health:
* Other:
 |
| Sickle Cell Screen/PRN | ☐ | ☐ |  |
| **Lead Level Required Grades Pre- K & K** | **Date** |
| * 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
* Dental
* Neck
 | * Lymph nodes
* Cardiovascular
* Lungs
 | * Abdomen
* Back/Spine
* Genitourinary
 | * Extremities
* Skin
* Neurological
 | * Speech
* Social Emotional
* Musculoskeletal
 |
| * Assessment/Abnormalities Noted/Recommendations:
* Additional Information Attached
 | Diagnoses/Problems (list) | ICD-10 Code |
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| --- | --- |
| Name: | DOB: |
| **SCREENINGS** |
| **Vision** | **Right** | **Left** | **Referral** | **Notes** |
| Distance Acuity | 20/ | 20/ | * Yes ☐ No
 |  |
| Distance Acuity With Lenses | 20/ | 20/ |  |  |
| Vision – Near Vision | 20/ | 20/ |  |  |
| Vision – Color ☐Pass ☐ Fail |  |  |
| **Hearing** | **Right** dB | **Left** dB | **Referral** |  |
| Pure Tone Screening |  |  | * Yes ☐ No
 |  |
| **Scoliosis** Required for boys grade 9 | **Negative** | **Positive** | **Referral** |  |
| And girls grades 5 & 7 | ☐ | ☐ | * Yes ☐ No
 |  |
| Deviation 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** Use the Interscholastic Sports Categories (below) for Restrictions or modifications
	+ **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, Skiing, 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.** |

CI T Y S C H O O L D I S T R I C T O F A L B A N Y B U R E AU

OF H E A L T H A N D P H Y S I C A L E D U C A T I O N

**S T U D E N T H E A L T H A P P R A I S A L**

Parent/Guardian:

New York State Education Law requires students to have a physical examination when they:

* Enter a school district for the first time
* Are in pre-K or kindergarten, first, third, fifth, seventh, ninth and eleventh grades
* Participate in interscholastic sports
* Need working papers
* Are referred to the Committee on Special Education or are scheduled for a triennial review
* Require an appraisal deemed necessary by school authorities to determine an appropriate educational program

The physical appraisal must describe the condition of the student when the examination was made, which may be no more than twelve months prior to the commencement of the school year in which the examination is required.

If the appraisal is for participation in interscholastic sports, it must be completed no more than 12 months prior to the first day of practice/tryouts for the selected sport.

Contact the School Nurse if you have any questions.