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| NYS SCHOOL HEALTH EXAMINATION FORM  |
| Student Information |
| Name: Sex:  | DOB: \_\_\_\_\_\_\_\_\_Date of Exam: \_\_\_\_\_\_\_\_\_ School: Grade: |
| Health History |
| Problem List Items with ICD 10 code: | Height: \_\_\_\_\_\_\_\_ (Percentile: \_\_\_\_\_\_\_)Weight: \_\_\_\_\_\_\_\_ (Percentile: \_\_\_\_\_\_\_)BMI: \_\_\_\_\_\_\_\_ kg/m2 (Percentile: \_\_\_\_\_\_)BMI Percentile Category (Weight Status Category)Blood Pressure: \_\_\_\_\_\_\_\_ mmHg |
| Allergies:  |
| Significant Past Medical History& Additional Problems:  |
| Laboratory and Diagnostic Testing |
| Results of Tuberculosis testing (if indicated by Risk factors): Type of Test: \_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_\_\_\_\_\_\_\_Results of Sickle Cell testing (if done): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results of Lead testing (if Pre-K or Kindergarten): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| VisionRight Left Pass/Fail Date: Distance Acuity \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ Near vision\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_ Color (Pass/Fail): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hearing (Pure Tone Screening):Right Left (Pass/Fail) 500 Hz1000 Hz2000 Hz4000 Hz6000 Hz8000 Hz |
| Abnormal Physical Examination Findings |
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| Assessment and Recommendations |
| RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK |
| Chronic Medications:  |
| Immunization Record:See NYSIIS |
| Additional Information: |
| Health Care ProviderSignature: | Name:Address: Phone number: Fax number: |
| Date Form Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |