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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 Hz  1000 Hz  2000 Hz  4000 Hz  6000 Hz  8000 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 Provider  Signature: | Name:  Address:  Phone number:  Fax number: |
| Date Form Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |