REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

**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

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>School:</th>
<th>Grade:</th>
<th>Exam Date:</th>
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### HEALTH HISTORY

**Allergies**  □ No  □ Yes, indicate type

- Type: □ Medication/Treatment Order Attached  □ Anaphylaxis Care Plan Attached

- **Asthma**  □ No  □ Yes, indicate type

- Intermittent □ Persistent □ Other: □ Medication/Treatment Order Attached  □ Asthma Care Plan Attached

- **Seizures**  □ No  □ Yes, indicate type

- Date of last seizure: □ Medication/Treatment Order Attached  □ Seizure Care Plan Attached

- **Diabetes**  □ No  □ Yes, indicate type

- Type: □ 1 □ 2  □ Medication/Treatment Order Attached  □ 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/m2

**Percentile (Weight Status Category):**  □ <5th  □ 5th-49th  □ 50th-84th  □ 85th-94th  □ 95th-98th  □ 99th and>

**Hyperlipidemia:**  □ No  □ Yes  □ Not Done  □ Hypertension:**  □ No  □ Yes  □ Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sickle Cell Screen-PRN</td>
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**Lead Level Required Grades Pre- K & K**  Date

- □ Test Done □ Lead Elevated > 5 µg/dL

- □ System Review and Abnormal Findings Listed Below

- □ HEENT □ Lymph nodes □ Abdomen □ Extremities □ Speech
- □ Dental □ Cardiovascular □ Back/Spine □ Skin □ Social Emotional
- □ Neck □ Lungs □ Genitourinary □ Neurological □ Musculoskeletal

- □ Assessment/Abnormalities Noted/Recommendations: □ Diagnoses/Problems (list)  ICD-10 Code*

- □ Additional Information Attached

*Required only for students with an IEP receiving Medicaid
**SCREENINGS**

<table>
<thead>
<tr>
<th>Vision (w/correction if prescribed)</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>☐</td>
<td>☐</td>
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</table>

**Notes**

**Hearing** 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.

<table>
<thead>
<tr>
<th>Pure Tone Screening</th>
<th>Right</th>
<th>Pass</th>
<th>Fail</th>
<th>Left</th>
<th>Pass</th>
<th>Fail</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

**Notes**

**Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7

<table>
<thead>
<tr>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
<th>Not Done</th>
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<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐ Yes</td>
<td>☐ No</td>
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**RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK**

- ☐ Student may participate in all activities without restrictions.
- ☐ Student is restricted from participation in:
  - ☐ Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
  - ☐ Other Restrictions:

**Developmental Stage for Athletic Placement Process ONLY required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage**: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : ____________

- ☐ Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

**MEDICATIONS**

- ☐ Order Form for Medication(s) Needed at School Attached

**IMMUNIZATIONS**

- ☐ Record Attached ☐ Reported in NYSIIS

**HEALTH CARE PROVIDER**

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child’s School When Completed.