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 ☐ No
☐ Yes, 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: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c 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):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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.

EASTPORT-SOUTH MANOR CENTRAL SCHOOL DISTRICT
149 Dayton Avenue, Manorville, NY 11949

NAME OF CHILD: _____

HEALTH HISTORY INFORMATION

Has your child ever had any of the following? ☐ Yes ☐ No

☐ Pneumonia	☐ Whooping Cough	☐ Tonsillitis
☐ Tuberculosis	☐ German measles	☐ Frequent Colds
☐ Rheumatic Fever	☐ Asthma	☐ Hearing Loss
☐ Epilepsy	☐ Diabetes	☐ Vision Problems
☐ Chicken Pox	☐ Anemia or Sickle Cell	☐ Heart Trouble
☐ Measles	☐ Mononucleosis	☐ Skin Disorder
☐ Mumps	☐ Kidney Trouble	☐ Hernias

Is there anything concerning the eyes, ears, or health of this child which the school should know in order to provide special care?

_____

_____

ALLERGY SCREENING

If your child has an allergy (such as food, medication, or environmental) please answer the following questions:

1. Is your child allergic to anything? ☐ YES ☐ NO
   Please include any food, medication or environmental allergies
   Please specify allergen and your child's reaction (i.e. hives, rash, shortness of breath, etc.): _____
   _____
   _____
2. Does your child have a prescribed EpiPen for this allergy? ☐ YES ☐ NO
3. Is your child at risk for a life-threatening allergic reaction? ☐ YES ☐ NO
4. Has your child's allergy been identified through allergy testing? ☐ YES ☐ NO
5. Please check circumstances which reaction could occur: ☐ Contact ☐ Ingestion ☐ Airborne

ASTHMA

If your child has asthma, please answer the following questions:

1. Does your child have asthma? ☐ YES ☐ NO
2. Does your child use an inhaler or a nebulizer at home? ☐ YES ☐ NO
3. Will medication be required for use during school hours? ☐ YES ☐ NO

Parent Signature: **Date:**

Please Complete Side Two

NAME OF CHILD: _____

ILLNESS, INJURY OR OPERATION

Has your child, during the past year had any illness, injury or operation? If so, please write name and date of illness below.

_____

_____

_____

MEDICATIONS

Please list any medications your child is presently taking.

_____

_____

_____

*If your child's physician requires an over the counter medication or prescription medication during school hours, a doctor's order along with parent/guardian consent must be obtained.

- **The medication must be brought to school by a parent/guardian in the original container.**
- **Medication cannot be transported on the school bus.**

In the event of an emergency where a parent cannot be reached, I give permission for my child to receive medical treatment.

Parent Signature: **Date:**

PHYSICAL EXAMINATION

A physical examination by a private physician or the school physician, on entry of school and routinely at **grades, K, 2, 4, 7 & 10 is compulsory.**

Please check the appropriate item:

_____ I wish to have my child examined by the family physician at my expense and will submit a report to the school by October 15th or 30 days after entry for students newly enrolled in the district. **If the results of your child's examination have not been received by this date, the school physician will examine your child.**

_____ I wish to have my child examined **without cost** by the school physician.

Parent Signature: **Date:**