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

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

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	Type: ☐ Medication/Treatment Order Attached Date of last seizure: ☐ 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

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
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

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Near Vision Acuity	20/	20/		
Color Perception Screening ☐ Pass ☐ Fail				
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.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> 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, prostectic, sports goggle, 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.

PREPARTICIPATION MEDICAL HISTORY

This section should be completed by parent/guardian and athlete prior to the time of the medical examination and taken by the student to the examination site for review by the medical examiner.

Have you ever had any of the following conditions? *PLEASE EXPLAIN ANY "YES" ANSWERS*	
Heart Murmur	☐Yes ☐No
High Blood Pressure	☐Yes ☐No
Other Heart Problems	☐Yes ☐No
Fainting or Passing out - -If so, how many times and when:	☐Yes ☐No
Ever been Knocked out – If so, how many times and when:	☐Yes ☐No
Concussion - -If so, Please give dates and outcome, hospitalized, etc	☐Yes ☐No
Seizure or Epilepsy - - If so, when was last seizure	☐Yes ☐No
Asthma or breathing difficulties	☐Yes ☐No
Other Respiratory Problems	☐Yes ☐No
Ever had to stop running after a short distance due to chest pain, palpitations, dizziness, or shortness of breath	☐Yes ☐No
Anemia, Sickle Cell Trait, or Blood disorder	☐Yes ☐No
Mononucleosis - - If so, when	☐Yes ☐No
Diabetes or High Blood Sugar	☐Yes ☐No
Low Blood Sugar	☐Yes ☐No
Arthritis or Joint Problems	☐Yes ☐No
Broken bones If so, describe:	☐Yes ☐No
Any glasses, contacts, or vision Problems - - If so, describe:	☐Yes ☐No
Any Dental Appliances during sports - - If so, describe:	☐Yes ☐No
Any skin disorders - - If so , describe:	☐Yes ☐No
Do you have only one of a normally paired organ (i.e. Kidney, testicle, ovary, eye)	☐Yes ☐No
Do you require any special sports requirements (i.e. Knee braces, neck rolls, foot orthotics, etc.)	☐Yes ☐No
Have you ever been hospitalized? - - If so, why and when:	☐Yes ☐No
Have you had any operations? If so, describe:	☐Yes ☐No
Have you ever had an illness lasting a week or more?	☐Yes ☐No
Have you ever had allergies to the following:	
*Bee Stings If so, Do you require an Epi-Pen?	☐Yes ☐No
*Foods - - If so, what foods:	☐Yes ☐No
*Medicine - - If so, which medications and reactions:	☐Yes ☐No
Do you take any medicines regularly or periodically?	☐Yes ☐No
Which medications:	☐Yes ☐No
Do you wear contact lenses, eyeglasses, or dental appliances? (Circle those that apply)	☐Yes ☐No
Do you have any missing or non-functioning organs?	☐Yes ☐No
Do you have any other health problems?	☐Yes ☐No
Has any family member had a heart attack, heart problems, or sudden death before the age of 50?	☐Yes ☐No
Females: Have you begun menses yet?	☐Yes ☐No
Have you had a series of Hepatitis B shots?	☐Yes ☐No
Date of last Tetanus Immunization ____ / ____ / ____	☐Yes ☐No
Have you ever been denied full participation in athletic activity? - - If so, Why:	☐Yes ☐No
Questions or concerns regarding this student's medical history?	☐Yes ☐No

Mandatory Section

Parental Signature_____ Date_____

Name of Child's Doctor _____

Doctor's signature indicating review and agreement if done by Child's Primary Provider
_____ Date_____

My signature below indicates I request my child receive a sport's physical at school:

_____ Date_____