# 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:</th>
<th>M</th>
<th>F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Health History

<table>
<thead>
<tr>
<th>Allergies</th>
<th>No</th>
<th>Yes, indicate type</th>
<th>Type:</th>
<th>Medication/Treatment Order Attached</th>
<th>Anaphylaxis Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>No</td>
<td>Yes, indicate type</td>
<td>Intermittent</td>
<td>Persistent</td>
<td>Other:</td>
</tr>
<tr>
<td>Seizures</td>
<td>No</td>
<td>Yes, indicate type</td>
<td>Type:</td>
<td>Medication/Treatment Order Attached</td>
<td>Seizure Care Plan Attached</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
<td>Yes, indicate type</td>
<td>Type:</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**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>
<th>List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Level Required Grades Pre-K &amp; K</td>
<td>□ Test Done</td>
<td>□ Lead Elevated &gt;5 µg/dL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**System Review and Abnormal Findings Listed Below**

- □ HEENT
- □ Dental
- □ Neck
- □ Lungs
- □ Back/Spine
- □ Abdomen
- □ Genitourinary
- □ Extremities
- □ Skin
- □ Neurological
- □ Speech
- □ Social Emotional
- □ 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>□ Pass</td>
<td>□ Fail</td>
<td></td>
<td></td>
</tr>
</tbody>
</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 Pass Fail</th>
<th>Left Pass Fail</th>
<th>Referral Yes No</th>
<th>Not Done</th>
</tr>
</thead>
</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 Yes No</th>
<th>Not Done</th>
</tr>
</thead>
</table>

### 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 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.*