REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Affirmed Name (if applicable):</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Assigned at Birth:</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Gender Identity:</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

- ☐ Allergies
  - Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

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

- ☐ Seizures
  - Type: ☐ Medication/Treatment Order Attached
  - Date of last seizure: ☐ Seizure Care Plan Attached

- ☐ Diabetes
  - 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: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Lead Level Required for PreK &amp; K</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>☐ Test Done ☐ Lead Elevated &gt;5 µg/dL</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

- ☐ HEENT ☐ Lymph nodes ☐ Abdomen
- ☐ Dental ☐ Cardiovascular ☐ Back/Spine/Neck
- ☐ Mental Health ☐ Lungs ☐ Genitourinary
- ☐ Extremities ☐ Skin ☐ Speech
- ☐ Neurological ☐ Social Emotional ☐ Musculoskeletal
- ☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

5/2023
# SCREENINGS

## Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

<table>
<thead>
<tr>
<th>Vision Screening</th>
<th>With Correction</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>☐ Yes ☐ No</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>☐ Yes ☐ No</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐</td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>☐ Pass ☐ Fail</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Notes**

**Hearing Screening:** 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 ☐</th>
<th>Not Done</th>
</tr>
</thead>
</table>

**Notes**

**Scoliosis Screening:** Boys grade 9, Girls grades 5 & 7

<table>
<thead>
<tr>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

# FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

- ☐ *Family cardiac history reviewed* – required for Dominic Murray Sudden Cardiac Arrest Prevention Act
- ☐ Student may participate in all activities without restrictions.

If Restrictions Apply – Complete the information below

- ☐ 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

- ☐ Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

# MEDICATIONS

- ☐ Order Form for medication(s) needed at school attached

# COMMUNICABLE DISEASE

- ☐ Confirmed free of communicable disease during exam

# IMMUNIZATIONS

- ☐ Record Attached ☐ Reported in NYSIIS

# HEALTHCARE PROVIDER

- Healthcare Provider Signature:
- **Provider Name:** *(please print)*
- Provider Address:
- Phone: ☐ Fax:

Please Return This Form to Your Child’s School Health Office When Completed.