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>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

### HEALTH HISTORY

#### Allergies

- □ No
- □ Yes, indicate type

#### Asthma

- □ No
- □ Yes, indicate type

#### Seizures

- □ No
- □ Yes, indicate type

#### Diabetes

- □ No
- □ Yes, indicate type

#### 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):

- □ <5<sup>th</sup>  □ 5<sup>th</sup>-49<sup>th</sup>  □ 50<sup>th</sup>-84<sup>th</sup>  □ 85<sup>th</sup>-94<sup>th</sup>  □ 95<sup>th</sup>-98<sup>th</sup>  □ 99<sup>th</sup> 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>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td></td>
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</tr>
</tbody>
</table>

#### Lead Level Required Grades Pre-K & K

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

#### System Review and Abnormal Findings Listed Below

- □ HEENT
- □ Dental
- □ Neck

- □ Lymph nodes
- □ Cardiovascular
- □ Lungs

- □ Abdomen
- □ Back/Spine
- □ Genitourinary

- □ Extremities
- □ Skin
- □ Neurological

- □ Speech
- □ Social Emotional
- □ Musculoskeletal

#### Assessment/Abnormalities Noted/Recommendations:

- □ Additional Information Attached

#### List Other Pertinent Medical Concerns

(e.g. concussion, mental health, one functioning organ)

#### Diagnoses/Problems (list)

ICD-10 Code*  

*Required only for students with an IEP receiving Medicaid
### Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11

<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>20/20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>20/20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>☐ Pass ☐ Fail</td>
<td></td>
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</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>
<th></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</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
</tr>
</tbody>
</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.