

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HgbA1c 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	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 μ g/dL				<input type="checkbox"/> Other: _____

☐ System Review and Exam Entirely Normal

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____
<input type="checkbox"/> Additional Information Attached		

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9	Negative	Positive	Referral	
And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain				
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Brace*/Orthotic </div> <div> <input type="checkbox"/> Colostomy Appliance* </div> <div> <input type="checkbox"/> Hearing Aids </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Insulin Pump/Insulin Sensor* </div> <div> <input type="checkbox"/> Medical/Prosthetic Device* </div> <div> <input type="checkbox"/> Pacemaker/Defibrillator* </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Protective Equipment </div> <div> <input type="checkbox"/> Sport Safety Goggles </div> <div> <input type="checkbox"/> Other: </div> </div>				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> 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.				

YPS PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
☐ _____ which requires rapid administration of _____
(State Diagnosis) (Medication Name)

Signature: _____ **Date:** _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ **Date:** _____

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email:



Provider and Parent Permission to Administer Medication
at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

Parent/Guardian Signature _____

_____ Date

_____ Email

_____ Phone Where We Can Reach You ☐ Check if Cell

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ Per MEDICAID requirements, frequency & duration as indicated "per" IEP when appropriate.

☐ Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)

NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

Stamp

_____ Name/Title of Prescriber (Please Print)

_____ Date

_____ Prescriber's Signature

_____ Phone

_____ Email

Return to:

School Nurse: _____ School: _____

School Address: _____

Phone: () _____ Fax: () _____ Email _____