

# 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

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

### HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

**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:**     Yes     Not Done                      **Hypertension:**     Yes     Not Done

### PHYSICAL EXAMINATION/ASSESSMENT

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 µg/dL
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

**System Review Within Normal Limits**

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

<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/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<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*
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Additional Information Attached \*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision Screening</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
Notes					
<b>Hearing Screening:</b> 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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
<b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> 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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					

Sachem Central School District  
**STUDENT HEALTH HISTORY UPDATE**

Name:	DOB: Grade:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:	

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

**CHECK ALL THAT APPLY TO YOUR CHILD:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ADHD<br><input type="checkbox"/> Asthma/trouble breathing<br><input type="checkbox"/> Autism/Asperger<br><input type="checkbox"/> Dental Injuries<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)<br><input type="checkbox"/> Headaches/migraines<br><input type="checkbox"/> Heart Conditions<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Mental Health Condition<br>(depression, eating disorder, anxiety,<br>OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Single Organ ( <input type="checkbox"/> kidney, <input type="checkbox"/> testicle)<br><input type="checkbox"/> Skin Condition<br><input type="checkbox"/> Speech Condition<br><input type="checkbox"/> Urinary Condition |
|--|---|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

**FAMILY HEART HEALTH HISTORY**

A relative has/had any of the following:

Check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated<br>Cardiomyopathy<br><input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy?<br><input type="checkbox"/> Heart rhythm problems, long or short QT interval? | <input type="checkbox"/> Brugada Syndrome?<br><input type="checkbox"/> Catecholaminergic Ventricular Tachycardia?<br><input type="checkbox"/> Marfan Syndrome (aortic rupture)?<br><input type="checkbox"/> Heart attack at age 50 or younger?<br><input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)? |
|--|--|

A family history of:

- Known heart abnormalities or sudden death before age 50?  Structural heart abnormality, repaired or unrepaired?  
 Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

Name:	Affirmed Name (if applicable):	DOB:
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<b>If you answered YES to any questions give details. Sign and date below.</b>	
Parent/Guardian Signature:	Date:

Is there any condition that would prevent your child from participating in physical education?  
 No     Yes: \_\_\_\_\_

Please list any additional concerns: (use back of sheet if necessary) \_\_\_\_\_  
 \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_