

**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

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

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$				
<input type="checkbox"/> System Review and Abnormal Findings Listed Below				
<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			*Required only for students with an IEP receiving Medicaid	

Sachem Central School District

STUDENT HEALTH HISTORY UPDATE

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

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

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

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: _____

Sachem Central School District Athletic Participation Form (APF)

Two Page Form Both pages must be completed.

Student Name:		DOB:	
School Name:		Age:	
Grade (check):	<input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	Level (check):	<input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity
Sport:		Limitations:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last health exam:		Date form completed:	

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back. Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:		
General Health concerns:	Yes	No
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other		
3. Ever had surgery?		
4. Ever spent the night in a hospital?		
5. Been diagnosed with Mononucleosis within the last month?		
6. Have only one functioning kidney?		
7. Have a bleeding disorder?		
8. Have any problems with his/her hearing or wears hearing aid(s)?		
9. Have any problems with his/her vision or has vision in only one eye?		
10. Wear glasses or contacts?		
Allergies:	Yes	No
11. Have a life threatening allergy? If Yes, check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health:	Yes	No
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14. Wheeze or cough frequently during or after exercise?		
15. Ever been told by their health care provider they have asthma?		
16. Use or carry an inhaler or nebulizer?		

Has/Does your child:		
Concussion/Head Injury History:	Yes	No
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18. Have you ever had a head injury or concussion?		
19. Ever had headaches with exercise?		
20. Ever had any unexplained seizures?		
21. Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations:	Yes	No
22. Use a brace, orthotic, or other device?		
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.		
24. Wear protective eyewear, such as goggles or a face shield?		
Family History:	Yes	No
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only:	Yes	No
26. Begun having her period?		
27. Age periods began:		
28. Have regular periods		
29. Date of last menstrual period:		
Males Only:	Yes	No
30. Have only one testicle?		
31. Have groin pain or a bulge or hernia in the groin?		

Sachem Central School District Medical Athletic Participation Form (APF)-Page 2

Student Name: _____

School Name: _____

DOB: _____

Has/Does your child:			
Heart Health:		Yes	No
32.	Ever passed out during or after exercise?		
33.	Ever complained of light headedness or dizziness during or after exercise?		
34.	Ever complained of chest pain, tightness or pressure during or after exercise?		
35.	Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36.	Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37.	Ever been told they have a heart condition or problem by a physician? If so, check all that apply: <input type="checkbox"/> Heart infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____		
Injury History:		Yes	No
38.	Ever been diagnosed with a stress fracture?		

Has/Does your child:			
Injury History continued:		Yes	No
39.	Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40.	Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41.	Have a bone, muscle, or joint injury that bothers him/her?		
42.	Have joints become painful, swollen, warm, or red with use?		
Skin Health:		Yes	No
43.	Currently have any rashes, pressure sores, or other skin problems?		
44.	Have had a herpes or MRSA skin infections?		
Stomach Health:		Yes	No
45.	Ever become ill while exercising in hot weather?		
46.	Have a special diet or have to avoid certain foods?		
47.	Have to worry about his/her weight?		
48.	Have stomach problems?		
49.	Have you ever had an eating disorder?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known. Note: "Yes" answers to any of these questions does not mean automatic disqualification from the athletic activity indicated. They will require review and evaluation by the school physician.

Risk Acknowledgement and Permission: I give permission for _____ to participate in any sports for which the examining physician or school nurse have determined there are no disqualifying conditions. I fully understand that my child may not participate in any practice, scrimmage or contest without proper clearance. Further, I acknowledge that with participation in interscholastic athletics comes the risk of injury. These risks vary from sport to sport and can range from minor to catastrophic in nature. In addition, I also recognize that there are risks involved with team travel to contest sites at opposing school facilities. I give permission for my child to undergo a medical examination by district approved physicians. If I choose to have the examination performed by a family physician, then I agree to have the information completed on the appropriate school forms. I also agree that in some cases, district appointed physicians shall have the right to review the information provided my family physicians and retain the right of final approval. I clearly understand that the questions are asked in order to decide if this student is in proper condition to participate in the sports named at the top of this form. The answers are correct as of the date this form is signed. All answer will be kept confidential in his/her record in the school health office. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____