

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

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

HEALTH HISTORY

Specify Current Diseases	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done Date: _____
<input type="checkbox"/> Asthma (<input type="checkbox"/> Intermittent or <input type="checkbox"/> Persistent)	PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done Date: _____
Quick relief inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No	Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done Date: _____
Asthma Action Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done Date: _____
<input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Allergies - See page 2 for details.
<input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension	
<input type="checkbox"/> Other:	
Significant Medical/Surgical Information:	

PHYSICAL EXAMINATION

Height:	Weight:	BP:	Pulse:	Respirations:			
Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive			Vision		Right	Left	Referral
Degree of deviation: _____			Distance acuity				<input type="checkbox"/> Yes <input type="checkbox"/> No
Angle of trunk rotation via scoliometer: _____			Distance acuity with lenses				
Body Mass Index:			Vision - near vision				
Weight Status Category (BMI Percentile):			Vision - color perception		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	
<input type="checkbox"/> <5 th	<input type="checkbox"/> 85 th - 94 th						
<input type="checkbox"/> 5 th - 49 th	<input type="checkbox"/> 95 th - 98 th	Hearing		Right	Left	Referral	
<input type="checkbox"/> 50 th - 84 th	<input type="checkbox"/> 99 th & higher	<input type="checkbox"/> 20 db sweep screen both ears or				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V							
<input type="checkbox"/> SYSTEM REVIEW AND EXAM ENTIRELY NORMAL				<input type="checkbox"/> See attached			
Specify any abnormalities:							

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

<input type="checkbox"/> Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school) <input type="checkbox"/> Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball, <input type="checkbox"/> Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing, <input type="checkbox"/> Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking <input type="checkbox"/> Protective Equipment: <input type="checkbox"/> Athletic Cup <input type="checkbox"/> Sport/safety goggles <input type="checkbox"/> Other: <input type="checkbox"/> Medical/prosthetic device: <input type="checkbox"/> Recommendations/restrictions:
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Name:

DOB:

MEDICATIONS**To be completed by Health Care Provider**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

***Self Directed:** I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry:** I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: _____

Date: _____

Phone: () _____

Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: _____

Date: _____

Phone: () _____

ALLERGIES None Non Life-Threatening Life-ThreateningType: Food Insect Latex Medication Seasonal/Environmental Other:

Specify allergen(s): _____

Specify previous symptoms: _____

History of anaphylaxis; last occurrence: _____Emergency Care Plan for anaphylaxis: Yes NoTreatment prescribed: None Antihistimine Epinephrine Autoinjector**IMMUNIZATIONS** Immunization record attached Immunizations received today: Immunizations reported on NYSIIS No immunizations received today Will return on: _____ to receive: _____**Provider / Parental Authorization****All information contained herein is valid through the last day of the month for 12 months from the date below.**

Medical Provider Signature: _____

Date: _____

Provider Name: (please print) _____

Phone #: _____

Provider Address: _____

Fax #: _____

Parent/Guardian Signature: _____

Date: _____

Return to:

School Nurse: _____

School: _____

Phone #: () _____

Fax: () _____

Date: _____