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: ☐ M ☐ F
School: Grade: ☐NA Exam Date: / /

HEALTH HISTORY

Specify Current Diseases					
☐Asthma (☐Intermittent or ☐Persistent)	Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date: / /
Quick relief inhaler ☐Yes ☐No	PPD:	☐Positive	☐Negative	☐Not Done	Date: / /
Asthma Action Plan: ☐Yes ☐No	Elevated Lead:	☐Yes	☐No	☐Not Done	Date: / /
☐Type 1 Diabetes ☐Type 2 Diabetes	Dental Referral:	☐Yes	☐No	☐Not Done	Date: / /
☐Hyperlipidemia ☐Hypertension	☐ Allergies - See page 2 for details.				
☐Concussions ☐Other:					

Significant Medical/Surgical Information: ______________________

PHYSICAL EXAMINATION

Height: ________ Weight: ________ BP: ________ Pulse: ________ Respirations: ________

Scoliosis: ☐Negative ☐Positive
Degree of deviation: ______
Angle of trunk rotation via scoliometer: __________

Body Mass Index: _____ _____ - _____
Weight Status Category (BMI Percentile):
☐ <5th ☐ 85th- 94th
☐ 5th- 49th ☐ 95th- 98th
☐ 50th-84th ☐ 99th & higher

Vision:	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐ Pass	☐ Fail	

Hearing:	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: I. II. III. IV. V.

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL
Specify any abnormalities: ______________________

☐ See attached.

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

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

Name: ______________________ DOB: ___/___ /___

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

***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-Threatening**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: ______________________________ ☐History of anaphylaxis; last occurrence:__________

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐ 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 # ______________