# 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

## HEALTH HISTORY

### Allergies
- □ No
- □ Yes, indicate type

### Asthma
- □ No
- □ Yes, indicate type
- □ Intermittent
- □ Persistent
- □ Other:

### Seizures
- □ No
- □ Yes, indicate type

### Diabetes
- □ No
- □ Yes, indicate type
- □ 1
- □ 2

### 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

### 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>
- □ 99th and>

### Hyperlipidemia:
- □ No
- □ Yes
- □ Not Done

### Hypertension:
- □ No
- □ Yes
- □ Not Done

## PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB-PRN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen-PRN</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lead Level Required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grades Pre-K &amp; K</td>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>□ Test Done</td>
<td>□ Lead Elevated &gt; 5 µg/dL</td>
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</tbody>
</table>

### System Review and Abnormal Findings Listed Below
- □ HEENT
- □ Dental
- □ Neck
- □ Lymph nodes
- □ Cardiovascular
- □ Lungs
- □ Abdomen
- □ Back/Spine
- □ Genitourinary
- □ Extremities
- □ Skin
- □ Neurological
- □ Speech
- □ Social Emotional
- □ Musculoskeletal

### Assessment/Abnormalities Noted/Recommendations:
- □ Additional Information Attached

### Diagnoses/Problems (list)

### ICD-10 Code*

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*Required only for students with an IEP receiving Medicaid.
### SCREENINGS

<table>
<thead>
<tr>
<th>Vision (w/correction if prescribed)</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Not Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Near Vision Acuity</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color Perception Screening</td>
<td>☐ Pass</td>
<td>☐ Fail</td>
<td></td>
<td></td>
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<tr>
<td>Notes</td>
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**Hearing** 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.

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<th>Pure Tone Screening</th>
<th>Right</th>
<th>☐ Pass</th>
<th>☐ Fail</th>
<th>Left</th>
<th>☐ Pass</th>
<th>☐ Fail</th>
<th>Referral</th>
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<th>☐ No</th>
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### RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

- ☐ Student may participate in all activities without restrictions.
- ☐ Student is restricted from participation in:
  - ☐ **Contact Sports**: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
  - ☐ **Limited Contact Sports**: Baseball, Fencing, Softball, and Volleyball.
  - ☐ **Non-Contact Sports**: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
  - ☐ **Other Restrictions**:

**Developmental Stage for Athletic Placement Process ONLY required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage**: ☐ ☐ I ☐ II ☐ III ☐ IV ☐ V  

**Age of First Menses (if applicable)**: ___________

- ☐ **Other Accommodations***: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain.  
  *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

### MEDICATIONS

- ☐ Order Form for Medication(s) Needed at School Attached

### IMMUNIZATIONS

- ☐ Record Attached  
- ☐ Reported in NYSIIS

### HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:  
Fax:

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**Please Return This Form To Your Child’s School When Completed.**