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)
Quick relief inhaler ☐Yes ☐No
Asthma Action Plan: ☐Yes ☐No
☐Type 1 Diabetes ☐Type 2 Diabetes
☐Hyperlipidemia ☐Hypertension
☐Other:

Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date: / /
PPD:	☐Positive	☐Negative	☐Not Done	Date: / /
Elevated Lead:	☐Yes	☐No	☐Not Done	Date: / /
Dental Referral:	☐Yes	☐No	☐Not Done	Date: / /

☐ Allergies - See page 2 for details.

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	☐ Immunizations received today:
☐ 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: _____