



New York State Health Examination Form
NYACK PUBLIC SCHOOLS

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

Note: NYSED requires a physical exam for new entrants and students in Grades pre-K or K, 1, 3, 5, 7, 9 & 11, all interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: M F
 School: _____ Grade: No Grade Exam Date: _____

IMMUNIZATIONS

Immunization record attached
 Immunizations reported on NYSIS
 No immunizations received today

Immunizations received today:
 Will return on: _____ to receive: _____

HEALTH HISTORY

Asthma: Intermittent Persistent Medication: _____ Asthma Action Plan Attached
 Diabetes: Type I Type 2 Hyperlipidemia Hypertension Diabetes Medical Mgmt Plan Attached
 Seizures Type: _____ Last Occurrence: _____ Emergency Care Plan Attached
 Allergies: Non Life-Threatening Life-Threatening Emergency Care Plan Attached
 Type: Food Insect Latex Medication Seasonal/Environmental Other:
 Allergen(s): _____
 Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____
 Treatment prescribed: None Antihistimine Epinephrine Autoinjector : 0.3mg 0.15mg

Significant Medical/Surgical Information: Positive Diagnostic Tests		Negative	Not Done	Date
Sickle Cell Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision one eye only One functioning kidney One testicle Concussion - Last occurrence: _____

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			<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Status Category (BMI Percentile): <input type="checkbox"/> <5th <input type="checkbox"/> 85th - 94th <input type="checkbox"/> 5th - 49th <input type="checkbox"/> 95th - 98th <input type="checkbox"/> 50th - 84th <input type="checkbox"/> 99th & higher	Vision - near vision			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vision - color perception	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hearing	Right	Left	Referral
	<input type="checkbox"/> 20 db sweep screen both ears or			<input type="checkbox"/> Yes <input type="checkbox"/> No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: I II III IV V

SYSTEM REVIEW AND EXAM ENTIRELY NORMAL Additional information attached
 Specify any abnormalities: _____

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

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations. Please base restrictions/modifications on the following Interscholastic Sports Categories.

No Contact Sports includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling

No Non-Contact Sports includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton

Other Specific Restrictions:

Insulin Pump/ Sensor Pacemaker/Accommodations Athletic Cup Brace/Orthotic Medical /Prosthetic Device
 Sports Safety Goggles /Protective Other: Hearing Aides/Equipment:

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

Required Medication Form (Independent Carry and Use Attestation) documentation is attached.

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child.

Parent/Guardian Signature: _____

HEALTH CARE PROVIDER

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 #: () _____

Return to:

School Nurse: _____ School: _____
 Phone #: () _____ Fax: () _____ Date: _____