



## New York State Health Examination Form NYACK HIGH SCHOOL

**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		<b>Vision</b>		<b>Right</b>	<b>Left</b>	<b>Referral</b>
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
<b>Weight Status Category (BMI Percentile):</b> <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
		<b>Hearing</b>		<b>Right</b>	<b>Left</b>	<b>Referral</b>
		<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: Margaret (Peggy) D’Auria, RN School: Nyack High School  
 Phone #: (845)-353-7140 Fax: (845)353-7147 Email: mdauria@nyackschools.org