NYACK PUBLIC SCHOOLS

New York State Health Examination Form

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.

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Gender:</th>
<th>School:</th>
<th>Grade:</th>
<th>No Grade Exam Date:</th>
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IMMUNIZATIONS

- Immunization record attached
- Immunizations reported on NYSIIS
- No immunizations received today

- Will return on: _______ to receive:

HEALTH HISTORY

- Asthma: Intermittent Persistent Medication: ___________ Asthma Action Plan Attached
- Diabetes: Type 1 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

<table>
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<tr>
<th>Tests</th>
<th>Negative</th>
<th>Not Done</th>
<th>Date</th>
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<tbody>
<tr>
<td>Sickle Cell Screen</td>
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<tr>
<td>PPD</td>
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<tr>
<td>Elevated Lead:</td>
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</table>

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

PHYSICAL EXAMINATION

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<tr>
<th>Scoliosis:</th>
<th>Negative</th>
<th>Positive</th>
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Degree of deviation: ___________
Angle of trunk rotation via scoliometer: ___________

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<tr>
<th>Weight Status Category (BMI Percentile):</th>
<th>&lt;5th</th>
<th>5th - 49th</th>
<th>50th - 84th</th>
<th>85th - 94th</th>
<th>95th - 98th</th>
<th>99th &amp; higher</th>
</tr>
</thead>
</table>

Weight: ___________
Height: ___________
BP: ___________

Vision: Right | Left | Referral
|___________|_______|__________|
Distance acuity | Yes | No
Distance acuity with lenses | Yes | No

Vision - near vision | Yes | No
Vision - color perception | Pass | Fail | Yes | No

Hearing: Right | Left | Referral
|___________|_______|__________|
20 db sweep screen both ears or | Yes | No

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

- 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.

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<tr>
<th>Diagnosis</th>
<th>ICD Code</th>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
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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: ________________