**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.

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Gender: □M □F</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>□No Grade Exam Date:</td>
</tr>
</tbody>
</table>

### IMMUNIZATIONS

- [ ] Immunization record attached
- [ ] Immunizations reported on NYSIIS
- [ ] 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 Type: □ Food □ Insect □ Latex □ Medication □ Seasonal/Environmental □ Other: ____________
- [ ] Hx of Anaphylaxis: Last occurrence: ____________ Previous symptoms: ____________
- [ ] Treatment prescribed: □ None □ Antihistimine □ Epinephrine Autoinjector: □ 0.3mg □ 0.15mg

**Significant Medical/Surgical Information**

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

- [ ] Vision one eye only □ One functioning kidney □ One testicle □ Concussion - Last occurrence:

### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Respirations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoliosis: □ Negative □ Positive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Degree of deviation: ____________

Angle of trunk rotation via scoliometer: ____________

**Weight Status Category (BMI Percentile):**

- □ <5th
- □ 5th - 49th
- □ 50th - 84th
- □ 85th - 94th
- □ 95th - 98th
- □ 99th & higher

**Vision:**

- Distance acuity: □ Yes □ No
- Distance acuity with lenses: □ Yes □ No

**Hearing:**

- 20 db sweep screen both ears: □ Yes □ No

**Check developmental stage** (ONLY for Athletic Placement Process for 7th & 8th graders): □ 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 SpecificRestrictions:
  - 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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD Code</th>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
</tr>
</thead>
</table>

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: ___________________________ Date: ___________________________

Phone #: ( ______ ) Fax: ( ______ )
Allergy Action Plan - Requires MD signature

Student: ___________________________ D.O.B: __________ Gr: __________

ALLERGY TO:

Asthmatic: □ Yes* □ No *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION - Systems: Symptoms:
• MOUTH itching & swelling of the lips, tongue, or mouth
• THROAT* itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
• SKIN hives, itchy rash, and/or swelling about the face or extremities
• GUT nausea, abdominal cramps, vomiting, and/or diarrhea
• LUNG* shortness of breath, repetitive coughing, and/or wheezing
• HEART* “thready” pulse, “passing-out”

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life threatening situation.

ACTION FOR MINOR REACTION
1. If the only symptom(s) are: MILD - hives, itchy rash or itchy eyes
2. Give Benadryl: 25mg PO, may repeat in 1 hour if symptoms have not resolved

Notify:
Parent/Guardian: __________________________________________

If condition worsens, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION
1. If ingestion is suspected and/or symptom(s) are: Moderate to Severe - Multi-system or respiratory involvement
2. IMMEDIATELY administer EPIPEN: 0.15mg / 0.3mg Epinephrine IM to outer thigh

□ → Student may self carry EPIPEN and self administer medication as per MD orders

(High School & Middle School ONLY. Elementary students may not self carry).

*MD Signature: ___________________________ Date: ______ STAMP:

Then call:
1. 911 (ask for advanced life support and EPIPEN)
2. Parent/Guardian: ___________________________ at ___________________________
3. Dr. ___________________________ at ___________________________

DO NOT HESITATE TO CALL 911!

School RN signature: ___________________________ Date: ___________________________
ASTHMA Management plan

Student: ______________________ DOB ________ Grade _________

☐ Inhaler: Circle one: Albuterol/Maxair/Proair/Proventil/Ventolyn/Other: _____________
1-2 puffs - 15 minutes prior to gym or sports or Q4 hours PRN.

☐ ☐ Medication to be kept in Nurse’s Office and administered by School RN.
   Please be advised that all medication for Elementary students will be kept in Nurse’s Office.

☐ ☐ Student may self carry inhaler and administer medication as per MD orders
   High School & Middle School ONLY. Elementary students may not self carry inhalers.

Immediate action is required if student exhibits any of the following signs of respiratory distress:
   Repetitive Cough - Shortness of Breath - Chest Tightness - Wheezing - Retractions

☐ Steps to take during asthma exacerbation:

   1. Administer emergency asthma medication as prescribed below with inhaler or nebulizer:

      Medication: ________________________________________________________________

   2. Reassess 10-15 minutes after medication administration.
      → If S & S have resolved, student may return to classroom.
      → Activate 911, if S & S above persist or if student continues to struggle to breathe.
      → Repeat emergency medication after 30 minutes if EMS has not arrived

*MD Signature: ______________________ Date: _____ STAMP:

Then call:
   1. Parent/Guardian: _______________________________________________________

   2. Dr. _____________________________ at ____________________________

DO NOT HESITATE TO CALL 911!

School RN signature: __________________________ Date: ______________