### Student Health Examination Form

Note: NYSED requires a physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers.

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

#### Immunizations

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

#### Health History

- **Asthma:** Intermittent / Persistent
- **Diabetes:** Type I / Type 2 / Hyperlipidemia / Hypertension
- **Seizures:** Type: ___________ Last Occurrence: ________
- **Allergies:** Non Life-Threatening / Life-Threatening
  - Type: Food / Insect / Latex / Medication / Seasonal/Environmental / Other:
  - Allergen(s):
  - Hx of Anaphylaxis: Last occurrence: ________ Previous symptoms: __________
  - Treatment prescribed: None / Antihistimine / Epinephrine Autoinjector

#### Significant Medical/Surgical Information:

<table>
<thead>
<tr>
<th>Diagnostic Tests</th>
<th>Positive</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>
<td>☐</td>
</tr>
<tr>
<td>PPD</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Elevated Lead:</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

- Will return on: __________ to receive:

#### Physical Examination

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Respirations:</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoliosis:</td>
<td>Neg.</td>
<td>Pos.</td>
<td></td>
<td></td>
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<tr>
<td>Degree of deviation:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Angle of trunk rotation via scoliometer:</td>
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</tbody>
</table>
| Weight Status Category (BMI Percentile):
  - <5th
  - 5<sup>th</sup> - 49<sup>th</sup>
  - 50<sup>th</sup> - 84<sup>th</sup>
  - 95<sup>th</sup> - 98<sup>th</sup>
  - 99<sup>th</sup> & higher | | | | | |
| Vision - near vision | ☐ | ☐ | | | |
| Vision - color perception | ☐ | ☐ | Fail | Yes | No |
| Hearing | Right | Left | | | |
| 20 db sweep screen both ears or | | | | | |

#### 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:

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

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 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>
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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: __________