

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR				
SOMERS INTERMEDIATE SCHOOL 240 Rt. 202·Somers, NY 10589			Fax# 914-277-3168 Tel.# 914-277-4034	
Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).				
STUDENT INFORMATION				
Name:			Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:			Grade:	Exam Date:
HEALTH HISTORY				
Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental		
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached <input type="checkbox"/> <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____		
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached <input type="checkbox"/> Type: _____ Date of last seizure: _____		
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____		
Risk Factors for Diabetes or Pre-Diabetes: <i>Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.</i>				
BMI _____ kg/m2 Percentile (Weight Status Category): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and>				
Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes		Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes		
PHYSICAL EXAMINATION/ASSESSMENT				
Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K				<input type="checkbox"/> Mental Health: _____
Date				<input type="checkbox"/> Other: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				
<input type="checkbox"/> System Review and Exam Entirely Normal				

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

- | | | | | |
|---------------------------------|---|--|---------------------------------------|---|
| <input type="checkbox"/> HEENT | <input type="checkbox"/> Lymph nodes | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Extremities | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Back/Spine | <input type="checkbox"/> Skin | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Lungs | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Musculoskeletal |

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

☐ Additional Information Attached

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Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9	Negative	Positive	Referral	
And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions:				

<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V		
<input type="checkbox"/> Accommodations: Use additional space below to explain <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div><input type="checkbox"/> Brace*/Orthotic</div> <div><input type="checkbox"/> Colostomy Appliance*</div> <div><input type="checkbox"/> Hearing Aids</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div><input type="checkbox"/> Insulin Pump/Insulin Sensor*</div> <div><input type="checkbox"/> Medical/Prosthetic Device*</div> <div><input type="checkbox"/> Pacemaker/Defibrillator*</div> <div><input type="checkbox"/> Protective Equipment</div> <div><input type="checkbox"/> Sport Safety Goggles</div> <div><input type="checkbox"/> Other:</div> </div> <p style="font-size: small; margin-top: 5px;">*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.</p>		
Explain: _____		
MEDICATIONS		
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached		
List medications taken at home:		
IMMUNIZATIONS		
<input type="checkbox"/> Record Attached	<input type="checkbox"/> Reported in NYSIIS	Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH CARE PROVIDER		
Medical Provider Signature:	Date:	
Provider Name: <i>(please print)</i>	Stamp:	
Provider Address:		
Phone:		
Fax:		
Please Return This Form To Your Child's School When Entirely Completed.		