

NEWBURGH ENLARGED CITY SCHOOL DISTRICT

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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____	DOB: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
School: _____	Grade: <input type="checkbox"/> No Grade	Exam Date: _____

IMMUNIZATIONS	
<input type="checkbox"/> Immunization record attached	<input type="checkbox"/> Immunizations received today:
<input type="checkbox"/> Immunizations reported on NYSIIS	
<input type="checkbox"/> No immunizations received today	<input type="checkbox"/> Will return on: _____ to receive:

HEALTH HISTORY	
<input type="checkbox"/> Asthma <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent	<input type="checkbox"/> Asthma Action Plan Attached
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes Medical mgmt. Plan attached
<input type="checkbox"/> Seizures Type: _____ Last Occurrence: _____	<input type="checkbox"/> Emergency Care Plan Attached
<input type="checkbox"/> Allergies: <input type="checkbox"/> Non-Life-Threatening <input type="checkbox"/> Life-Threatening	<input type="checkbox"/> Emergency Care Plan Attached
Type: <input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Seasonal/Environmental <input type="checkbox"/> Other:	
Allergen(s): _____	
<input type="checkbox"/> Hx of Anaphylaxis: _____ Last Occurrence: _____ Previous symptoms: _____	
Treatment prescribed: <input type="checkbox"/> None <input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine Auto injector	

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	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 Degree of deviation: _____ Angle of trunk rotation via scoliometer: _____ Weight Status Category (BMI Percentile): _____ <input type="checkbox"/> < 5 th <input type="checkbox"/> 85 th – 94 th <input type="checkbox"/> 5 th – 49 th <input type="checkbox"/> 95 th – 98 th <input type="checkbox"/> 50 th – 84 th <input type="checkbox"/> 99 th & higher	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Vision</th> <th style="width:10%;">Right</th> <th style="width:10%;">Left</th> <th style="width:50%;">Referral</th> </tr> </thead> <tbody> <tr> <td>Distance Acuity</td> <td></td> <td></td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Distance acuity with lenses</td> <td></td> <td></td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Vision – near vision</td> <td></td> <td></td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Vision – color perception</td> <td><input type="checkbox"/> Pass</td> <td><input type="checkbox"/> Fail</td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <th style="width:30%;">Hearing</th> <th style="width:10%;">Right</th> <th style="width:10%;">Left</th> <th style="width:50%;">Referral</th> </tr> <tr> <td><input type="checkbox"/> 20 db sweep screen both ears</td> <td></td> <td></td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Dental Referral</td> <td></td> <td></td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> </tbody> </table>	Vision	Right	Left	Referral	Distance Acuity			<input type="checkbox"/> yes <input type="checkbox"/> no	Distance acuity with lenses			<input type="checkbox"/> yes <input type="checkbox"/> no	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	Hearing	Right	Left	Referral	<input type="checkbox"/> 20 db sweep screen both ears			<input type="checkbox"/> yes <input type="checkbox"/> no	Dental Referral			<input type="checkbox"/> yes <input type="checkbox"/> no
Vision	Right	Left	Referral																														
Distance Acuity			<input type="checkbox"/> yes <input type="checkbox"/> no																														
Distance acuity with lenses			<input type="checkbox"/> yes <input type="checkbox"/> no																														
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																														
Hearing	Right	Left	Referral																														
<input type="checkbox"/> 20 db sweep screen both ears			<input type="checkbox"/> yes <input type="checkbox"/> no																														
Dental Referral			<input type="checkbox"/> yes <input type="checkbox"/> no																														

Check development stage (ONLY for Athletic Placement Process for 7 th & 8 th graders)	Tanner: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V
---	--

<input type="checkbox"/> SYSTEM REVIEW AND EXAM ENTIRELY NORMAL Specify any abnormalities: _____	<input type="checkbox"/> Additional Information Attached
---	--

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:	<input type="checkbox"/> Athletic Cup	<input type="checkbox"/> Insulin Pump/Insulin Sensor	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Brace/Orthotic	<input type="checkbox"/> Medical/Prosthetic Device	<input type="checkbox"/> Sports Safety Goggles
	<input type="checkbox"/> Hearing Aides	<input type="checkbox"/> 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 auto injector, 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 document 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: _____
 Provider Name: (please print) _____
 Provider Address: _____

Date: _____
 Phone #: () _____
 Fax#: () _____

Return to:

School: _____

Phone #: _____

Fax #: _____