REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY 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; 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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐Type 1 ☐ Type 2 ☐ HgbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
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.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and<

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **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:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

LIVONIA
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Since April 2003, HIPPA (Health Information Proliferation Privacy Act) requires you to complete the form below for your healthcare provider to share protected health information with the school district. Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____authorize my child's healthcare provider(s) listed below to release the medical records of my child_____ DOB:_____, to the District's:
☐ Medical Officer, ☐ School Nurse, ☐ Occupational Therapist (OT), ☐ Physical Therapist (PT), ☐ Speech Therapist (ST),
☐ Athletic Trainer (AT), ☐ Psychologist, ☐ Social Worker, ☐ Counselor, ☐ Other (specify)
_____

Parent; list all your child's healthcare providers below:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

The healthcare provider may disclose the following protected health information: PARENT/SCHOOL: check all that apply

☐ Immunizations
☐ Health Appraisals
☐ Past/Current Medical Condition and Its Impact on Attendance, Athletics, or School Programming or Therapy(ies)
☐ Other: _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): PARENT/SCHOOL: check all that apply

☐ To develop care or therapy plans for routine and emergent school management
☐ To design appropriate educational, school, or athletic programs
☐ To assess the impact of the medical condition(s) on school programming and/or attendance
☐ To share school observations/concerns surrounding behavior
☐ To assess a medical basis for modification of transportation and/or home tutoring
☐ Medication delivery or therapy prescriptions
☐ At patient's request with no specified purpose
☐ Other: _____

PARENT: Please select one (Note: If you do not sign for the complete academic year, you may need to complete another form)

☐ This authorization is valid for the entire academic school year 20_____-20_____
☐ This authorization shall expire on _____ / _____ / _____ (MM/DD/YY)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the healthcare providers listed.

Date: _____ **Signature of Patient (over 18), Parent, or Guardian**:_____ **Relationship**: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD
REQUIRES MEDICATION IN SCHOOL, PLEASE SIGN THE PERMISSION BELOW

I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider

Name: _____ **Date:** _____

This exam complies with NYSED requirements above and is valid for twelve (12) months, with the exception of any illness or injury lasting more than five (5) days that will require review by private healthcare and the school medical director