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: □ M □ F

School: Grade: □ No Grade **Exam Date:**

IMMUNIZATIONS

□ Immunization record attached □ Immunizations received today:
□ Immunizations reported on NYSIIS
□ No immunizations received today □ Will return on: to receive:

HEALTH HISTORY

□ **Asthma** □ Intermittent □ Persistent □ 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 □Emergency Care Plan Attached
Type: □ Food □ Insect □ Latex □ Medication □ Seasonal/Environmental □ Other:
Allergen(s):_____
□ Hx of Anaphylaxis: Last Occurrence: Previous symptoms:
Treatment prescribed: □ None □ Antihistamine □ Epinephrine Auto injector

Significant Medical/Surgical Information:	**Diagnostic Tests**	**Positive**	**Negative**	**Not Done**	**Date**
_____	Sickle Cell Screen	□	□	□	
_____	PPD	□	□	□	
_____	Elevated Lead	□	□	□	

□ **Vision one eye only** □ **One functioning kidney** □ **One testicle** □ **Concussion – Last occurrence:**

PHYSICAL EXAMINATION

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

Scoliosis: □ Negative □ Positive
Degree of deviation: _____
Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile): ___ ___.___
□ < 5th □ 85th – 94th
□ 5th – 49th □ 95th – 98th
□ 50th – 84th □ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance Acuity			□ yes □ no
Distance acuity with lenses			□ yes □ no
Vision – near vision			□ yes □ no
Vision – color perception	□ Pass	□ Fail	□ yes □ no
Hearing	**Right**	**Left**	***Referral***
□20 db sweep screen both ears			**□ yes □ no**
Dental Referral			□ yes □ no

Check development 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:

Rev. 3/16

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 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: _____ Date:

Provider Name: (please print) _____ Phone #: ( )

Provider Address: _____ Fax#: ( )

Return to:

School: **Phone #:** **Fax #:**