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 ☐ Will return on: ____________ to receive:
☐ No immunizations received today

HEALTH HISTORY
☐ Asthma ☐ Intermittent ☐ Persistent
☐ Diabetes ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Seizures ☐ Type: Last Occurrence: ☐ Asthma Action Plan Attached
☐ 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 ☐ Antihistamine ☐ Epinephrine Auto injector

Significant Medical/Surgical Information:

Diagnostic Tests Positive Negative Not Done Date
________________________________________________________________________

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

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

☐ 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:**

<table>
<thead>
<tr>
<th>Accommodations/ Protective Equipment:</th>
<th>□ Athletic Cup</th>
<th>□ Insulin Pump/Insulin Sensor</th>
<th>□ Pacemaker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Brace/Orthotic</td>
<td>□ Medical/Prosthetic Device</td>
<td>□ Sports Safety Goggles</td>
</tr>
<tr>
<td></td>
<td>□ Hearing Aides</td>
<td>□ Other:</td>
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</tbody>
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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.**

<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:**   **Phone #:**   **Fax #:**