REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

	Negative	**Positive**	**Referral**	**Not Done**
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Health History for Athletics Both pages must be completed by Parent/Guardian & signed where indicated.			
Student Name:		School:	
Address:	DOB:		Age:
Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12	Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity		
Sport:	Limitations: ☐ Yes ☐ No		

Health History to Be Completed by Parent/Guardian, Provide Details to Any Yes Answers on Back.

Medicines needed at practice and/or athletic event require the proper paperwork, contact school with questions.

Has/Does your child:

General Health Concerns	No	Yes
1. Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
2. Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3. Ever had surgery?	☐	☐
4. Ever spent the night in a hospital?	☐	☐
5. Been diagnosed with Mononucleosis within the last month?	☐	☐
6. Have only one functioning kidney?	☐	☐
7. Have a bleeding disorder?	☐	☐
8. Have any problems with his/her hearing or wears hearing aid(s)?	☐	☐
9. Have any problems with his/her vision or has vision in only one eye?	☐	☐
10. Wear glasses or contacts?	☐	☐
Allergies		
11. Have a life-threatening allergy? Check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12. Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health	**No**	**Yes**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	☐	☐
14. Wheeze or cough frequently during or after exercise?	☐	☐
15. Ever been told by a health care provider they have asthma?	☐	☐
16. Use or carry an inhaler or nebulizer?	☐	☐

Has/Does your child:

Concussion/ Head Injury History	No	Yes
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	☐	☐
18. Ever had a head injury or concussion?	☐	☐
19. Ever had headaches with exercise?	☐	☐
20. Ever had any unexplained seizures?	☐	☐
21. Currently receive treatment for a seizure disorder or epilepsy?	☐	☐
Devices/Accommodations	**No**	**Yes**
22. Use a brace, orthotic, or other device?	☐	☐
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	☐	☐
24. Wear protective eyewear, such as goggles or a face shield?	☐	☐
Family History	**No**	**Yes**
25. Have any relative who's been diagnosed with a heart condition, such as a Murmur, developed Hypertrophic Cardiomyopathy, Marfan Syndrome, Brugada Syndrome, Right Ventricular Cardiomyopathy, Long QT or Short QT Syndrome, or Catecholaminergic Polymorphic Ventricular Tachycardia?	☐	☐
Females Only	**No**	**Yes**
26. Begun having her period?	☐	☐
27. Age periods began:		
28. Have regular periods?	☐	☐
29. Date of last menstrual period:		
Males Only	**No**	**Yes**
30. Have only one testicle?	☐	☐
31. Have groin pain or a bulge or hernia in the groin?	☐	☐

Health History for Athletics - Signature required below

Student Name: School:

Address: DOB:

Has/Does your child:

Heart Health	No	Yes
32. Ever passed out during or after exercise?	☐	☐
33. Ever complained of light headedness or dizziness during or after exercise?	☐	☐
34. Ever complained of chest pain, tightness or pressure during or after exercise?	☐	☐
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	☐	☐
36. Ever had a test by a health care provider for his/her heart (e.g. EKG, echocardiogram stress test)?	☐	☐

37. Ever been told they have a heart condition or problem by a health care provider? If so, check all that apply:

- ☐ Heart infection ☐ Heart Murmur
- ☐ High Blood Pressure ☐ Low Blood Pressure
- ☐ High Cholesterol ☐ Kawasaki Disease
- ☐ Other:

Injury History	No	Yes
38. Ever been diagnosed with a stress fracture?	☐	☐

Has/Does your child:

Injury History continued	No	Yes
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	☐	☐
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	☐	☐
41. Have a bone, muscle, or joint injury that bothers him/her?	☐	☐
42. Have joints become painful, swollen, warm, or red with use?	☐	☐

Skin Health	No	Yes
43. Currently have any rashes, pressure sores, or other skin problems?	☐	☐
44. Have had a herpes or MRSA skin infections?	☐	☐

Stomach Health	No	Yes
45. Ever become ill while exercising in hot weather?	☐	☐
46. Have a special diet or need to avoid certain foods?	☐	☐
47. Have to worry about his/her weight	☐	☐
48. Have stomach problems?	☐	☐
49. Ever had an eating disorder?	☐	☐

COVID-19 Information	No	Yes
50. Has your child ever tested positive for COVID-19?	☐	☐
51. Was your child symptomatic?	☐	☐
52. Did your child see a healthcare provider (HCP) for their COVID-19 symptoms?	☐	☐
53. Did your child have any cardiac symptoms (new fast or slow heart rate, chest tightness or pain, blood pressure changes, or HCP diagnosed cardiac condition)? If yes, please provide additional information.	☐	☐
54. Was your child hospitalized? If yes, provide date(s)?	☐	☐
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?	☐	☐
If yes, is your child under a HCP's care for this?	☐	☐

Please explain fully any question you answered yes to, in the space below. Include dates if known. Use additional pages if necessary.

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Parent/Guardian Signature:______________________ **Parent/Guardian Cell Number:** ______________

Date:______________