

**STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)**

**Note:** NYSED requires an annual 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:  NA Exam Date: / /

HEALTH HISTORY			
<b>Specify Current Diseases</b>	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done	Date: ___/___/___	
<input type="checkbox"/> Asthma ( <input type="checkbox"/> Intermittent or <input type="checkbox"/> Persistent)	PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done	Date: ___/___/___	
Quick relief inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No	Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done	Date: ___/___/___	
Asthma Action Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done	Date: ___/___/___	
<input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Allergies - See page 2 for details.		
<input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension			
<input type="checkbox"/> Other:			
Significant Medical/Surgical Information: _____			

PHYSICAL EXAMINATION				
Height: _____	Weight: _____	BP: _____	Pulse: _____	Respirations: _____
<b>Scoliosis:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive	<b>Vision:</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>
Degree of deviation: _____	Distance acuity			<input type="checkbox"/> Yes <input type="checkbox"/> No
Angle of trunk rotation via scoliometer: _____	Distance acuity with lenses			
<b>Body Mass Index:</b> _____ - _____	Vision - near vision			
Weight Status Category (BMI Percentile):	Vision - color perception	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	
<input type="checkbox"/> <5th <input type="checkbox"/> 85 <sup>th</sup> - 94 <sup>th</sup>	<b>Hearing:</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>
<input type="checkbox"/> 5 <sup>th</sup> - 49 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> - 98 <sup>th</sup>	<input type="checkbox"/> 20 db sweep screen both ears or			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 50 <sup>th</sup> - 84 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> & higher	Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: I. II. III. IV. V.			
<input type="checkbox"/> SYSTEM REVIEW AND EXAM ENTIRELY NORMAL				
Specify any abnormalities: _____				
<input type="checkbox"/> See attached.				

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK
<input type="checkbox"/> Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)
<input type="checkbox"/> Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,
<input type="checkbox"/> Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,
<input type="checkbox"/> Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking
<input type="checkbox"/> Protective Equipment: <input type="checkbox"/> Athletic Cup <input type="checkbox"/> Sport/safety goggles <input type="checkbox"/> Other: _____
<input type="checkbox"/> Medical/prosthetic device: _____
<input type="checkbox"/> Recommendations/restrictions: _____

### MEDICATIONS

#### To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

**\*Self Directed:** I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

**\*\*Self Admin/Self-Carry:** I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

#### To be completed by Parent/Guardian if medication is prescribed

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

### ALLERGIES

None                       Non Life-Threatening                       Life-Threatening

Type:  Food  Insect  Latex  Medication  Seasonal/Environmental  Other:

Specify allergen(s): \_\_\_\_\_

Specify previous symptoms: \_\_\_\_\_  History of anaphylaxis; last occurrence: \_\_\_\_\_

Emergency Care Plan for anaphylaxis:  Yes  No

Treatment prescribed:  None  Antihistimine  Epinephrine Autoinjector

### IMMUNIZATIONS

Immunization record attached

Immunizations reported on NYSIS

No immunizations received today

Immunizations received today:

Will return on \_\_\_\_/\_\_\_\_/\_\_\_\_ to receive:

#### Provider / Parental Authorization

**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 #: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Return to:**

School Nurse: Mrs. Dawn Ekstrom, RN

School: Robert H Jackson Elementary

Phone #: (716)569-7083

Fax: (716)569-7006

Date: \_\_\_\_\_