

## 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, 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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

## HEALTH HISTORY

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<b>Risk Factors for Diabetes or Pre-Diabetes:</b> 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.		
<b>BMI</b> _____ kg/m2 <b>Percentile (Weight Status Category):</b> <input type="checkbox"/> <5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> -49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> -84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> -94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> -98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and >		
<b>Hyperlipidemia:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Hypertension:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		

## PHYSICAL EXAMINATION/ASSESSMENT

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>TESTS</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Other Pertinent Medical Concerns</b>
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____
<input type="checkbox"/> System Review and Exam Entirely Normal				
<b>Check Any Assessment Boxes <u>Outside</u> Normal Limits And Note Below Under Abnormalities</b>				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			<b>Diagnoses/Problems (list)</b>	<b>ICD-10 Code</b>
			_____	_____
			_____	_____
			_____	_____
<input type="checkbox"/> Additional Information Attached				

**Brentwood Union Free School District**

Name:			DOB:	
<b>SCREENINGS</b>				
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys: grade 9 And girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
<b>Recommendations:</b>				
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>				
<input type="checkbox"/> <b>Full Activity</b> without restrictions including Physical Education and Athletics. <input type="checkbox"/> <b>Restrictions/Adaptations</b> Use the Interscholastic Sports Categories (below) for Restrictions or modifications <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> <b>No Contact Sports</b>   <input type="checkbox"/> <b>No Non-Contact Sports</b>   <input type="checkbox"/> <b>Other Restrictions:</b> </div> <div style="width: 65%;"> <b>Includes:</b> baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling   <b>Includes:</b> archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track &amp; field </div> </div>				
<input type="checkbox"/> <b>Developmental Stage for Athletic Placement Process ONLY</b> Grades 7 & 8 to play at high school level <b>OR</b> Grades 9-12 to play middle school level sports Student is at <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> <b>Accommodations:</b> Use additional space below to explain <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Brace*/Orthotic</div> <div style="width: 33%;"><input type="checkbox"/> Colostomy Appliance*</div> <div style="width: 33%;"><input type="checkbox"/> Hearing Aids</div> <div style="width: 33%;"><input type="checkbox"/> Insulin Pump/Insulin Sensor*</div> <div style="width: 33%;"><input type="checkbox"/> Medical/Prosthetic Device*</div> <div style="width: 33%;"><input type="checkbox"/> Pacemaker/Defibrillator*</div> <div style="width: 33%;"><input type="checkbox"/> Protective Equipment</div> <div style="width: 33%;"><input type="checkbox"/> Sport Safety Goggles</div> <div style="width: 33%;"><input type="checkbox"/> Other:</div> </div>				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
<b>MEDICATIONS</b>				
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School attached</b>				
List medications taken at home:				
<b>IMMUNIZATIONS</b>				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HEALTH CARE PROVIDER</b>				
Medical Provider Signature:			<b>Date:</b>	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
<b>Please Return This Form To Your Child's School When Entirely Completed.</b>				

## BRENTWOOD UNION FREE SCHOOL DISTRICT

### AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOLS AND AFTER SCHOOL ACTIVITIES

**INSTRUCTIONS TO PARENT/GUARDIAN:** According to New York State law, medication, including non-prescription (over the counter) products, **WILL NOT** be administered in school **UNLESS THE FOLLOWING ARE PROVIDED:**

1. Section A: A written order from a licensed prescriber for any and all products described below
2. Section B: A written statement from the parent or guardian requesting administration of the medication in school as ordered by the licensed prescriber
3. The parent or guardian must assume responsibility to have the product delivered directly to the health office in a properly labeled original container
4. Indication of ability for independent Use and Carry by MD and parent signatures

#### **A. PHYSICIANS'S PERMISSION FORM:** *Please complete all sections in Part A*

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage and Times Given: \_\_\_\_\_

Side Effects, if any \_\_\_\_\_

Duration: \_\_\_\_\_ Other recommendations? \_\_\_\_\_

**HEALTH CARE PROVIDER PERMISSION FOR INDEPENDENT USE AND CARRY-** I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ ALLERGY and requires Epinephrine Auto-Injector
- ☐ Asthma or respiratory condition and requires inhaled respiratory rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ \_\_\_\_\_ Which requires rapid administration of \_\_\_\_\_  
(State Diagnosis) (Medication Name)

Prescriber's Signature: \_\_\_\_\_ STAMP: \_\_\_\_\_

Prescriber's Phone Number: \_\_\_\_\_ DATE: \_\_\_\_\_

#### **B. PARENT/GUARDIAN PERMISSION (REQUIRED)**

I hereby request that the nurse administered such medication during the school day as prescribed by the above health care provider. This medication is to be administered as ordered during the present school year, or until terminated by written notice. We release the nurse and the **BUFSD** of any liability relative to the administration and/or reaction of the medication on the above named student.

I request that my child be permitted to carry/self-administer his/her medication at school and school sponsored activity if **the MD has indicated permission above**. I understand it is my responsibility to monitor my child on an ongoing basis to insure that he/she is carrying and taking medication as ordered. Staff intervention and support is needed only during an emergency.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ Student Grade: \_\_\_\_\_