

Amityville UFSD Health Examination Form

Appendix A

Sample Recommended Form Updated June 2015 - Page 1 of 2

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

| | |
|--|--|
| <input type="checkbox"/> Immunization record attached | <input type="checkbox"/> Immunizations received today: |
| <input type="checkbox"/> Immunizations reported on NYSIS | |
| <input type="checkbox"/> No immunizations received today | <input type="checkbox"/> Will return on: _____ to receive: _____ |

HEALTH HISTORY

Asthma: Intermittent Persistent Asthma Action Plan Attached

Diabetes: Type I 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 Antihistimine Epinephrine Autoinjector

| Significant Medical/Surgical Information: | Diagnostic Tests | Positive | Negative | Not Done | Date |
|---|--------------------|--------------------------|--------------------------|--------------------------|------|
| | Sickle Cell Screen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | PPD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Elevated Lead: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Vision one eye only One functioning kidney One testicle Concussion - Last occurrence: _____

PHYSICAL EXAMINATION

| | | | | | |
|--|----------------------|------------------|---------------------|---|--|
| Height: _____ | Weight: _____ | BP: _____ | Pulse: _____ | Respirations: _____ | |
| Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive | | Vision | | | |
| Degree of deviation: _____ | | | Right | Left | |
| Angle of trunk rotation via scoliometer: _____ | | | | Referral | |
| Weight Status Category (BMI Percentile): <input type="checkbox"/> <5 th <input type="checkbox"/> 85 th - 94 th <input type="checkbox"/> 5 th - 49 th <input type="checkbox"/> 95 th - 98 th <input type="checkbox"/> 50 th - 84 th <input type="checkbox"/> 99 th & higher | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Pass <input type="checkbox"/> Fail | |
| | | | | Hearing | Right |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Check developmental 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: _____

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: | <input type="checkbox"/> Athletic Cup | <input type="checkbox"/> Insulin Pump/Insulin Sensor | <input type="checkbox"/> Pacemaker |
| | <input type="checkbox"/> Brace/Orthotic | <input type="checkbox"/> Medical /Prosthetic Device | <input type="checkbox"/> Sports Safety Goggles |
| | <input type="checkbox"/> Hearing Aides | <input type="checkbox"/> 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 autoinjector, 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 documentation 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 Nurse: _____ | School: _____ |
| Phone #: () _____ | Fax: () _____ |
| | Date: _____ |