Remsenburg-Speonk Elementary School

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

Specify Current Diseases					
☐Asthma (☐Intermittent or ☐Persistent)	Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done	Date:
Quick relief inhaler: ☐Yes ☐No	PPD:	☐Positive	☐Negative	☐Not Done	Date:
Asthma Action Plan: ☐Yes ☐No	Elevated Lead:	☐Yes	☐No	☐Not Done	Date:
☐Type 1 Diabetes ☐Type 2 Diabetes	Dental Referral:	☐Yes	☐No	☐Not Done	Date:
☐Hyperlipidemia ☐Hypertension	☐ Allergies - See page 2 for details.				
☐Other:					

Significant Medical/Surgical Information:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _______

Angle of trunk rotation via scoliometer: ___________

Body Mass Index:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th- 94th

☐ 5th- 49th ☐ 95th- 98th

☐ 50th-84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐ Pass	☐ Fail	

Hearing	Right	Left	*Referral*
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: ☐I ☐ II ☐III ☐IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ See attached

Specify any abnormalities:

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)

☐ Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,

☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,

☐ Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking

☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:

☐ Medical/prosthetic device:

☐ Recommendations/restrictions:

Name: DOB:

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

***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

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: ( )

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 NYSIIS ☐ 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: School:

Phone #: ( ) Fax: ( ) Date: