POTSDAM CENTRAL SCHOOL

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 student 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	☐ Medication/Treatment (Order Attached) ☐ Anaphylaxis (Care Plan Attached) ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment (Order Attached) ☐ Asthma (Care Plan Attached) ☐ Intermittent ☐ Persistent ☐ Other: ____________
Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment (Order Attached) ☐ Seizure (Care Plan Attached) ☐ Type: ____________ Date of last seizure: ____________
Diabetes ☐ No ☐ Yes, indicate type	☐ Medication/Treatment (Order Attached) ☐ Diabetes Medical Mgmt. (Plan Attached) ☐ Type 1 ☐ Type 2 ☐ HbA1c results: ____________ Date Drawn: ____________

Risk Factor 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 ☐ 95th – 98th ☐ 99th and >

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done	☐ Lead Elevated ≥10 mg/dl		

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: ____________
☐ Mental Health: ____________
☐ Other: ____________

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)	ICD-10 Code
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

☐ Additional Information Attached

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Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right Db**	**Left Db**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUD/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptation** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, Rifle, skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodation:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

* Check with Athletic Governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: ______________________________

MEDICATIONS

☐ **Order Form for Medications(s) Needed at School Attached**

List medication taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS ☐ Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: (*please print*)	Stamp:
Provider Address:	
Phone:	
Fax:	
Please Return This Form To Your Child's School When Entirely Completed.	

Grades Pre-K – 4, please mail/fax to 29 Leroy Street, Attn: Elementary Nurse, Potsdam, NY 13676 or Fax to 315-265-5458

Grades 5 – 8, please mail/fax to 29 Leroy Street, Attn: Middle Nurse, Potsdam, NY 13676 or Fax to 315-265-8103

Grades 9 – 12, please mail/fax to 29 Leroy Street, Attn: High Nurse, Potsdam, NY 13676 or Fax to 315-265-8134