Instructions for Completion of the New York State School Health Examination Form

Education Law requires a physical exam for new entrants and students in grades pre- K or K, 1, 3, 5, 7, 9, and 11; annually for inter-scholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-school special education (CPSE). The date of examination must be noted on the form and be not more than 12 months prior to the start of the school year.

Health History

1. Chronic medical conditions should be listed in patient's problem list. ICD-10 codes should accompany diagnoses ONLY for patients who have Medicaid and have an Individualized Education Plan (IEP) for special education in school and receive related services (i.e. nursing, social worker/psychologist, PT/OT/ST, or special transportation). Alternatively, an order for services with the ICD10 codes included can be submitted separately.
2. Asthma, seizure disorders, life threatening allergies and diabetes must be included if diagnosed, and each require a separately attached care plan:

    a. Allergies - life threatening allergy care plans should specify what the patient is allergic to. See AAAI Sample Anaphylaxis Emergency Action Plan;
    b. Asthma - Asthma Action Plans should include medication orders along with directives. See NYSDOH Asthma Action Plan;
    c. Seizure disorders care plans should include date of last known seizure. See NYSCSH Seizure ECP with Medication Information ; and
    d. Diabetes- requires a Diabetes Medical Management Plan (DMMP) specifying the type of diabetes. See NYSDOH Diabetes Medical Management Plan;

3. Consider screening for T2DM if BMI% >85% and child has 2 or more risk factors: Family history of T2DM, ethnicity, symptoms of insulin resistance, history of gestational diabetes in the mother, and/or pre-diabetes.
4. Include hyperlipidemia and hypertension if diagnosed.
5. Include mention of unpaired eye, kidney or testicle if relevant.
6. Include mental health diagnoses where permitted by patient/family.
7. Under allergies, list all allergies including medication, food, insects, latex, and other environmental allergens.
8. Attach medication administration forms for medication which will be administered in school.
9. Include problems relevant to the child's needs at school if not included in the problem list .
10. Height, weight, and BMI must be provided including percentile for each, as well as marking appropriate BMI category. Those include <5th, 5th-49th, 50th-84th, 85th-94th, 95th-98th, 99th and greater.
11. Pulse and respiratory rate are to be documented for students with diagnosed respiratory or cardiac conditions whose baseline rates are outside the normal range for age.

Laboratory and Diagnostic Testing

1. Tuberculosis screening, if indicated and performed, should specify type of testing (PPD or Interferon-gamma release assay), result, and test date.
2. Results of most recent prior lead level testing is required for students in PreK and K if available. If no test results reported the family will be given educational information about lead poisoning by school personnel.
3. Sickle cell screening is optional based upon discretion of provider.
4. Screening for vision and hearing in grades PreK or K, 1, 3, 5, 7, and 11, and for scoliosis in grades 5 and 7 for girls, grade 9 for boys that is not done or reported on the school form will be performed by the school.
    - Vision screening should include the results of distance acuity testing in each eye (pass is 20/30 or better), an assessment of near vision acuity (pass is 20/40 or better). Color vision (pass/fail) is required if student is attending a new school. See NYSED Vision Screening Guidelines for Schools .
    - Hearing screening should be performed at 20 dB and pass or fail noted for each frequency (500Hz, 1000Hz, 2000Hz, 4000Hz); for children ≥11 years of age (grades 7 & 11) should also be screened for high frequency hearing loss by testing at 6000Hz and 8000Hz. See NYSED Hearing Screening Guidelines for Schools .

Instructions for Completion of the New York State School Health Examination Form

Physical Examination/ Assessment

1. A complete physical exam must include the following systems: HEENT, Dental, Neck, Lymph nodes, Lungs, Abdomen, Back/Spine including screening for scoliosis (see above grade levels), Genitourinary, Extremities, Skin, Neurological, Cardiovascular, Speech/Language, Social-Emotional, and Musculoskeletal. Abnormal findings on review of systems and physical exam should be noted.

Tanner Staging (1-5) is required ONLY for any student in Grades 7 or 8 to play sports at a high school level or Grades 9-12 to play middle school level sports

Assessment and Recommendations

1. State "has no restrictions" if applicable. Please note any restrictions on physical activity including participation in physical education, sports, playground and work. Include applicable limitations on participation in sports by level of contact:
    a. Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling
    b. Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball
    c. Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field

2. List any accommodations required for participation, including but not limited to: Brace/Orthotic, Insulin pump/sensor, Protective equipment, Colostomy appliance, Medical/Prosthetic device, Sport safety goggles, Hearing aids, Pacemaker/Defibrillator, etc. Specific approval and associated documentation may be required if use of device will occur during athletic competitions, please check with athletic governing body for more information.
3. Chronic medications needed **at school** should be listed and include- medication strength/concentration, formulation, dose, frequency, and timing- or indicate separate order attached.
4. Providers may attach an immunization form or refer to NYSIIS registry if record available and complete.
5. Referrals, such as those for abnormalities on vision or hearing screening should be noted.
6. Please include any additional information that may be useful to the school that is not otherwise solicited.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors 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 ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.