CONNETQUOT CENTRAL SCHOOL DISTRICT OF ISLIP

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: ☐N/A Exam Date:

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today: _____

☐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:		**Positive**	**Negative**	**Not Done**	**Date**
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

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

PHYSICAL EXAMINATION

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

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer: _____

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			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes☐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:

Name: _____ DOB: _____

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 Category

- ☐ **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	☐Sport Safety Goggles	☐Pacemaker
	☐Medical/Prosthetic Device	☐Athletic Cup	☐Insulin Pump/Insulin Sensor
	☐Brace/Orthotic	☐Hearing Aides	☐Other:

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____ _____

_____ _____

MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS REQUESTED BY HEALTH CARE PROVIDER

Independent Use and Carry 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 and parent/guardian permission to allow this option in schools.

☐ **Required Independent Use and Carry Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL - VALID FOR 1 YEAR

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: