

SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT

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

Immunization record attached Immunizations received today:
 Immunizations reported on NYSIS
 No 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:	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		Referral
Degree of deviation: _____				Right	Left	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angle of trunk rotation via scoliometer: _____				Distance acuity		<input type="checkbox"/> Yes <input type="checkbox"/> No
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				Distance acuity with lenses		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vision - near vision		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vision - color perception		<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Yes <input type="checkbox"/> No
				Hearing		Referral
				Right	Left	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> 20 db sweep screen both ears or		<input type="checkbox"/> Yes <input type="checkbox"/> No

Check developmental stage 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: Robin Thayer, RN School: Senior High
 Phone #: (518) 792-9987 Fax: (518) 792-5412 Date: _____