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 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:	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 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: ☐ 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 µg/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:

☐ Additional Information Attached

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

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/PLAYGROUND/WORK

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

☐ **Restrictions/Adaptations** 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 at high school level **OR** Grades 9-12 to play middle school level sports

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

☐ **Accommodations:** 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 Medication(s) Needed at School attached**

List medications 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.

Sachem Central School District Athletic Participation Form (APF)
Two Page Form Both pages must be completed.

Student Name:		DOB:	
School Name:		Age:	
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12		Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	
Sport:		Limitations: ☐ Yes ☐ No	
Date of last health exam:		Date form completed:	

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back. Any medications to be taken at practice and/or athletic event will require the proper paperwork,contact school with questions

Has/Does your child:			
General Health Concerns		**Yes**	**No**
1.	Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2.	Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease		
	☐ Other		
3.	Ever had surgery?		
4.	Ever spent the night in a hospital?		
5.	Been diagnosed with Mononucleosis within the last month?		
6.	Have only one functioning kidney?		
7.	Have a bleeding disorder?		
8.	Have any problems with his/her hearing or wears hearing aid(s)?		
9.	Have any problems with his/her vision or has vision in only one eye?		
10.	Wear glasses or contacts?		
Allergies		**Yes**	**No**
11.	Have a life threatening allergy? If Yes, check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine		
	☐ Pollen ☐ Other		
12.	Carry an epinephrine auto-injector?		
Breathing (Respiratory) Health		**Yes**	**No**
13.	Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14.	Wheeze or cough frequently during or after exercise?		
15.	Ever been told by their health care provider they have asthma?		
16.	Use or carry an inhaler or nebulizer?		

Has/Does your child:			
Concussion/ Head Injury History		**Yes**	**No**
17.	Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18.	Have you ever had a head injury or concussion?		
19.	Ever had headaches with exercise?		
20.	Ever had any unexplained seizures?		
21.	Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations		**Yes**	**No**
22.	Use a brace, orthotic, or other device?		
23.	Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.		
24.	Wear protective eyewear, such as goggles or a face shield?		
Family History		**Yes**	**No**
25.	Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Females Only		**Yes**	**No**
26.	Begun having her period?		
27.	Age periods began:		
28.	Have regular periods?		
29.	Date of last menstrual period:		
Males Only		**Yes**	**No**
30.	Have only one testicle?		
31.	Have groin pain or a bulge or hernia in the groin?		

Sachem Central School District Medical Athletic Participation Form (APF)-Page 2			
Student Name:			
School Name:		DOB:	

Has/Does your child:			
Heart Health		**Yes**	**No**
32.	Ever passed out during or after exercise?		
33.	Ever complained of light headedness or dizziness during or after exercise?		
34.	Ever complained of chest pain, tightness or pressure during or after exercise?		
35.	Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36.	Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37.	Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐Heart infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease		
	☐Other:		
Injury History		**Yes**	**No**
38.	Ever been diagnosed with a stress fracture?		

Has/Does your child:			
Injury History *continued*		**Yes**	**No**
39.	Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40.	Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41.	Have a bone, muscle, or joint injury that bothers him/her?		
42.	Have joints become painful, swollen, warm, or red with use?		
Skin Health		**Yes**	**No**
43.	Currently have any rashes, pressure sores, or other skin problems?		
44.	Have had a herpes or MRSA skin infections?		
Stomach Health		**Yes**	**No**
45.	Ever become ill while exercising in hot weather?		
46.	Have a special diet or have to avoid certain foods?		
47.	Have to worry about his/her weight?		
48.	Have stomach problems?		
49.	Have you ever had an eating disorder?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known. Note: "Yes" answers to any of these questions does not mean automatic disqualification from the athletic activity indicated. They will require review and evaluation by the school physician.

_____

_____

_____

_____

Risk Acknowledgement and Permission: I give permission for _____ to participate in any sports for which the examining physician or school nurse have determined there are no disqualifying conditions. I fully understand that my child may not participate in any practice, scrimmage or contest without proper clearance. Further, I acknowledge that with participation in interscholastic athletics comes the risk of injury. These risks vary from sport to sport and can range form minor to catastrophic in nature. In addition, I also recognize that there are risks involved with team travel to contest sites at opposing school facilities. I give permission for my child to undergo a medical examination by district approved physicians. If I choose to have the examination performed by a family physician, then I agree to have the information completed on the appreciate school forms. I also agree that in some cases, district appointed physicians shall have the right to review the information provided my family physicians and retain the right of final approval. I clearly understand that the questions are asked in order to decide if this student is in proper condition to participate in the sports named at the top of this form. The answers are correct as of the date this form is signed. All answer will be kept confidential in his/her record in the school health office. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Guardian Signature:_____ **Date:** _____

Student Signature:_____ **Date:** _____