ELMONT UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICES - PHYSICAL EXAMINATION FORM
ELMONT, NEW YORK 11003

Name: ______________________ **DOB:** __________ **Gender:** ☐Male ☐Female

School: **Grade:** ☐N/A

IMMUNIZATIONS

☐ Immunization record attached	☐Immunizations received today: ______________
☐ Immunizations reported on NYSIIS	
☐ No immunizations received today	☐Will return on: To receive:

HEALTH HISTORY

☐**Asthma**: *(if checked select severity and control status)*

Severity: ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Control: ☐Well-controlled ☐Poorly Controlled ☐Not Controlled

☐**Diabetes**: ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension

☐**Seizures:** Type: __________ Last Occurrence: __________

☐No Allergies noted **☐Allergies**: ☐Non Life-Threatening ☐Life-Threatening

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Environmental ☐Other:_________

Within the last 12 months:

☐ER visits____times ☐Oral Steroids____times

☐Asthma Action Plan Attached

☐Diabetes Medical Mgmt. Plan Attached

☐Seizure Action Plan Attached

☐Allergy Action Plan Attached

☐Emergency Care Plan Attached

Allergen(s): ______________________________

☐Hx of Anaphylaxis: Last occurrence: ______________ Previous symptoms:______________

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Auto injector

Significant Medical/Surgical Information: *ie ER, hospitalizations, childhood disease, surgery*		**Positive**	**Negative**	**Not Done**	**Date**
	Sickle Cell Screen	☐	☐	☐	
	PPD *(Mantoux Test)*	☐	☐	☐	
	Interferon Test *(IGRA)*	☐	☐	☐	
	Chest x-ray	☐	☐	☐	
	Lead Screening:	☐	☐	☐	

☐Vision 1 eye only ☐Hearing loss ☐ 1 Functioning kidney ☐1 Testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

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

Scoliosis:☐Negative ☐Positive Degree of deviation:_____

Referral: ☐ No ☐Yes:__________________

Amblyopia Screening: ☐Negative ☐Postive:__________

BMI Calculation: ______________

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: Tanner: ☐I ☐ II ☐III ☐IV ☐ V

Hemoglobin or Hematocrit: ______________ **Date:** __________

Urinalysis: ______________ **Date:** __________

Education Law Article 19 and Regulations of the Commissioner of Education (8 NYCRR) requires a physical examination of a public school student entering the school district for the first time, in grades PK or K, 2, 4, 7 and 10; and at any grade level by school administration, in their discretion to promote the educational interests of the student (8 NYCRR 136.3[b]).

GENERAL APPEARANCE

☐ **SYSTEM REVIEW AND EXAM ENTIRELY NORMAL** ☐ **Additional information attached**

Psychosocial Development ☐Nl ☐Abnl	HEENT ☐Nl ☐Abnl	Lymph nodes ☐Nl ☐Abnl	Abdomen ☐Nl ☐Abnl	Skin ☐Nl ☐Abnl
Language ☐Nl ☐Abnl	Teeth ☐Nl ☐Abnl	Lungs ☐Nl ☐Abnl	GU ☐Nl ☐Abnl	Neuro ☐Nl ☐Abnl
Behavioral ☐Nl ☐Abnl	Neck ☐Nl ☐Abnl	Heart ☐Nl ☐Abnl	Extremities ☐Nl ☐Abnl	Back/Spine ☐Nl ☐Abnl

Specify any abnormalities: ______________________

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/RECESS

☐ **Full Activity** without restrictions including Physical Education, Recess and Playground.

☐ **Restrictions/Adaptations:**

☐ **Accommodations**:	☐Protective Equipment	☐Glasses ☐Sport Safety Goggles	☐Pacemaker
	☐Medical/Prosthetic Device	☐Hearing Aide	☐Insulin Pump/Insulin Sensor
	☐Brace/Orthotic	☐Vagal Stimulator	☐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 auto injector, 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.**
Nursing Assessment Form must also be completed by school nurse for supervised/independent status.

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

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

☐ **Required "*Request for Medication/Perform Procedure in School* "documentation is attached.**

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse performs and assessment and determines my child can take their own medications, trained staff may assist my child to take their own medications. I give permission for my child's medication to accompany him/her on a field trip/school event. 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 exam date.

Stamp must be present:

Medical Provider Signature: ______________________

Provider Name: (please print) ______________________

Phone: ______________ Fax: ______________

Address: ______________________

Date of Exam: ______________________