

SULLIVAN WEST CENTRAL SCHOOL DISTRICT

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: <input type="checkbox"/> M <input type="checkbox"/> F
School:	Grade: <input type="checkbox"/> NA	Exam Date:

MEDICAL HISTORY			
Specify Current Diseases <input type="checkbox"/> Asthma (<input type="checkbox"/> Intermittent or <input type="checkbox"/> Persistent) Quick relief inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma Action Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Other:	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done	Date:	
	PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done	Date:	
	Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done	Date:	
	Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done	Date:	
<input type="checkbox"/> Allergies - See page 2 for details.			
Significant Medical/Surgical Information:			

PHYSICAL EXAMINATION					
Height:	Weight:	BP:	Pulse:	Respirations:	
Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Degree of deviation: _____ Angle of trunk rotation via scoliometer: _____		Vision			
		Right	Left	Referral	
Body Mass Index: Weight Status Category (BMI Percentile): <input type="checkbox"/> <5th <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			<input type="checkbox"/> Yes <input type="checkbox"/> No
		Distance acuity with lenses			
		Vision - near vision			
		Vision - color perception			<input type="checkbox"/> Pass <input type="checkbox"/> Fail
		Hearing			
		Right	Left	Referral	
		<input type="checkbox"/> 20 db sweep screen both ears or			<input type="checkbox"/> Yes <input type="checkbox"/> No
Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> SYSTEM REVIEW AND EXAM ENTIRELY NORMAL			<input type="checkbox"/> See attached		
Specify any abnormalities:					

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK
<input type="checkbox"/> Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school) <input type="checkbox"/> Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball, <input type="checkbox"/> Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing, <input type="checkbox"/> Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking <input type="checkbox"/> Protective Equipment: <input type="checkbox"/> Athletic Cup <input type="checkbox"/> Sport/safety goggles <input type="checkbox"/> Other: <input type="checkbox"/> Medical/prosthetic device: <input type="checkbox"/> Recommendations/restrictions:

Name:

DOB:

MEDICATIONS							
To be completed by Health Care Provider							
Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

***Self Directed:** I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry:** I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed	
<input type="checkbox"/> I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it. Parent/Guardian Signature: _____ Date: _____ Phone: () _____	
<input type="checkbox"/> Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below. Parent/Guardian Signature: _____ Date: _____ Phone: () _____	

ALLERGIES	
<input type="checkbox"/> None <input type="checkbox"/> Non Life-Threatening <input type="checkbox"/> Life-Threatening	
Type: <input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Seasonal/Environmental <input type="checkbox"/> Other: _____	
Specify allergen(s): _____	
Specify previous symptoms: _____ <input type="checkbox"/> History of anaphylaxis; last occurrence: _____	
Emergency Care Plan for anaphylaxis: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment prescribed: <input type="checkbox"/> None <input type="checkbox"/> Antihistimine <input type="checkbox"/> Epinephrine Autoinjector	

IMMUNIZATIONS	
<input type="checkbox"/> Immunization record attached <input type="checkbox"/> Immunizations reported on NYSIIS <input type="checkbox"/> No immunizations received today	<input type="checkbox"/> Immunizations received today: <input type="checkbox"/> Will return on: _____ to receive: _____

Provider/Parental Authorization	
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 #: _____
Parent/Guardian Signature: _____	Date: _____

Return to:	
School Nurse: _____	School: _____
Phone #: () _____	Fax: () _____
	Date: _____