

CHILD & ADOLESCENT	Prose
HEALTH EXAMINATION FORM	Print Class

NAG	ŧΒ	(OSIS)	

Health	OI Eddo	dion line	-SHETORI	12 11 -					_	
TO BE COMPLETED BY THE PA	RENT O	R GUARDIAN								
Child's Last Name	Fir	st Name		Middle Nam	е		Sex		Date (of Birth (Month/Day/Year)
								Male Male		-''
Child's Address				Hispanic/Latin ☐ Yes ☐ No		Check ALL that apply) ive Hawaiian/Pacific				Asian Black White
City/Borough	State	Zip Code	School/Cen	ter/Camp Nam	е		Ì	District Number		Phone Numbers Home
Health insurance Yes Parent/Guardian	Last Name	First fi	lame		Ema	ail				Cell
(including Medicaid)? 🗌 No 🗀 Foster Parent					1					Work
TO BE COMPLETED BY THE HEALT	H CARE	PRACTITIONER								
Birth history (age 0-6 yrs)	Do	es the child/adolescent								
Uncomplicated Premature: weeks gest		Asthma (check severity and at t persistent, check all current me				Ald Persistent Inhaled Corticosteroid		Moderate Persi Oral Staroid		Severe Persistent er Controller
□ Complicated by		Asthma Control Status		Well-controlled	□Р	apply Controlled or No				
Allergies 🗀 Nonc 🗀 Epi pen prescribed		Anaphylaxis Behavioral/mental health disi	order E	Seizure disord Speech, heari		npairment	Media No			fin-school medication needed) Yes (list below)
□ Drugs (list)		Congenital or acquired heart Developmental/learning prob	disorder [Tuberculosis (latent infection o		1	nio.		163 (161 06/00)
Fnods (list)		Diabetes <i>(attach MAF)</i> Orthopedic injury/disability		Surgery						
Other (list)	Exp	Orthopedic injury/disability olain all checked items abo	ve.	Other (specify) Addendum a						
Attach MAF if in-school medications needed PHYSICAL EXAM Date of Exam:/_	/ Cor	neral Appearance:	_						-	
	%ile)		Physical I	Exam WNL	***************					
	NI /	Abril	NI Abril		NI Abni		l Abni	domes	Î	NI Abni
		☐ Psychosocial Development ☐ Language	☐ ☐ HEENT☐ ☐ Dental		Lymph Lungs	1-		domen nitourinary		Skin Neurological
	- 70110)	E Behavioral	☐ ☐ Neck		Cardio			tremities		Back/spine
Head Circumference (age £2 yrs) cm (- volle) Des	scribe abnormalities:								
Blood Pressure (age ≥3 yrs) //	Mark	rition				Hearing		Dat	te Done	Results
DEVELOPMENTAL lage 0-6 yrsj Validated Screening Tool Used? Date S		year 🗌 Breastfed 🗀 Form	ula [] Both			< 4 years: gross	hooring		ie oune	
□ Yes □ No/_	, ≥1	year 🗀 Well-balanced 🗀 N	eeds guidanc		Referred	DAE OAE	i i o car ii i o			
Screening Results: ::: WNL	Diet	tary Restrictions 🗌 None [Yes (list be	low)		≟ 4 yrs: pure tone	audion			
Delay or Concern Suspected/Confirmed (specify area(s)		DEFENDING TEATO	ata Gana	Danul	1-	Vision			te Done	Results
☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help ☐ Communication/Language ☐ Gross Motor/Fine Motor	******	REENING TESTS Dood Lead Level (BLL)	ate Done	Resul		. <3 years: Vision a				_/
Social-Emotional or Other Area of Concern	(rec	quired at age yr and 2 and for those at risk)		/		Acuity (required for and children age 3			1	Left /Unable to test
Personal-Social Describe Suspected Delay or Concern:		ad Risk Assessment		At r	μg/dL isk <i>(do BLL)</i>	Screened with Gla	asses?			Yes . No
	(at	each well child	/	/		Strabismus?				☐ Yes ☐ No
	-	am, age 6 mo-6 yrs)	ild Care Only	Not	at risk	Dental Visible Tooth Deca				Yes . □ No
		—— Ch moglobin or		1	g/dl_	Urgent need for de		ferral (pain, s	welling,	120
Child Receives EI/CPSE/CSE services		matocrit	/		%	Dental Visit within	the pa	ist 12 months	S	☐ Yes ☐ No
CIR Number	TTT	Phys	sician Confirm	ed History of Va	ricella Infectio	ın 🗆				Report only positive immunity:
IMMUNIZATIONS – DATES										IgG Titers Date
отр/отар/от / / / /	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			_77_	T			/	/	Hepatitis B/
Td//	//_		/	MMR		//				Measles/
Palio/	r	/	7_/_2023	· Varicella	//	i		/	_	Mumps /
Hep B//	/	///	/ M	ening ACWY	//	=://		/	·/	Rubella/
Hib////////	/		/	Hep A		/		/	./	Varicella / /
PCV//				Rotavirus	//		-	/	<i>ī</i>	Polio 1/
Influenza/////	4			Mening B ner	//	- · - · - · · - · ·	-	/	-	Polio 2//_
	Rianneses	/Problems (list) ICD-		COMMENDATIO	NS DEU	II physical activity			_	F0110-3
ABBEDGMICHT TWO WIND (200:120)		man	**********	Restrictions (spe			********			
			Foli	low-up Needed	□No □	Yes, for				Appt. date:/
			Ref	erral(s):	None E	arly Intervention	IEF	Denta	al [_ Vision
				Other			911			
Health Care Practitioner Signature				Date Form	Completed	_//		OHMH PRAI	CTITION	IER
Health Care Practitioner Name and Degree (print)			Practitio	ner License No.	and State		- 1	PE OF EXAM	l: 🗆 Ñ.	AE Current
Facility Name			National	Provider Identif	ier (NPI)		Da	ite Reviewed:		I,D. NUMBER
Address		City		State	Zip		RE	/ VIEWER:	1	
Telephone	ax		E	Email			FC	RM ID#		

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTHCARE 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 Affirmed Name (if applicable): DOB: Name: Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X Sex Assigned at Birth: ☐ Female ☐ Male Grade: Exam Date: School: **HEALTH HISTORY** If yes to any diagnoses below, check all that apply and provide additional information. Type: ☐ Allergies ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other: ☐ Asthma ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached Date of last seizure: Type: ☐ Seizures ☐ Seizure Care Plan Attached ☐ Medication/Treatment Order Attached Type: □ 1 □ 2 □ Diabetes ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached 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 □ 85th-94th □ 95th-98th \square 99th and > □ < 5th ☐ 5th- 49th ☐ 50th- 84th Percentile (Weight Status Category): **Hypertension:** ☐ Yes ☐ Not Done Hyperlipidemia: ☐ Yes ☐ Not Done PHYSICAL EXAMINATION/ASSESSMENT Pulse: Respirations: BP: Height: Weight: Lead Level Positive Negative Date Laboratory Testing Date Required for PreK & K TB-PRN ☐ Test Done ☐ Lead Elevated ≥5 μg/dL Sickle Cell Screen-PRN ☐ System Review Within Normal Limits ☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ) ☐ Extremities ☐ Speech ☐ HEENT ☐ Lymph nodes ☐ Abdomen ☐ Social Emotional □ Dental ☐ Cardiovascular ☐ Back/Spine/Neck ☐ Skin ☐ Musculoskeletal ☐ Mental Health ☐ Lungs ☐ Genitourinary □ Neurological ☐ Assessment/Abnormalities Noted/Recommendations: Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

		Affirmed Name	e (if applicable):		DOB:
		SCREENINGS			
	Vision & Hearing Scre	eenings Required fo	or PreK or K, 1, 3, 5,	7, & 11	
Vision Screening	With Correction □Yes □ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	
Near Vision Acuity		20/	20/	☐ Yes	
Color Perception Scre	eening 🗆 Pass 🗆 Fail				
-	: Passing indicates student can he 11 also test at 6000 & 8000 Hz.	ear 20dB at all frequ	uencies: 500, 1000, 7	2000, 3000, 4000	Not Done
Pure Tone Screening	Right □ Pass □ Fail	Left □ Pass □	Fail Ref	erral 🗆 Yes	
lotes					
Scoliosis Screening	g: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
			TION (CDODTS*/DI		
	FOR PARTICIPATION IN				
*Family cardiac	: history reviewed – required for	Dominick Murray	Sudden Cardiac Arre	est Prevention Act	
Hockey,	ts: Basketball, Competitive Cheerle Lacrosse, Soccer, and Wrestling.	eading, Diving, Dow	nhill Skiing, Field Hoo	key, Football, Gymn	astics, Ice
□ Non-Contact □ Other Restrice Developmental St. high school intersect Tanner Stage: □ □ □ Other Accomm	age for Athletic Placement Procesholastic sports level OR Grades 9	ling, Cross-Country, ess <u>ONLY</u> required -12 who wish to place, insulin pump,	Golf, Riflery, Swimm for students in Graday at the modified in prosthetic, sports gog	des 7 & 8 who wish aterscholastic sports	to play at the slevel.
□ Non-Contact □ Other Restrice Developmental St. high school intersect Tanner Stage: □ □ □ Other Accomm	Sports: Archery, Badminton, Bowletions: age for Athletic Placement Procedure of the Proced	ling, Cross-Country, ess ONLY required 1-12 who wish to plants brace, insulin pump, form completion is r MEDICATION	for students in Graay at the modified in prosthetic, sports gog equired for use of the S	des 7 & 8 who wish aterscholastic sports agles, etc.):	to play at the slevel.
□ Non-Contact □ Other Restrice Developmental St. high school intersect Tanner Stage: □ □ □ Other Accomm	Sports: Archery, Badminton, Bowletions: age for Athletic Placement Procedure of the Proced	ling, Cross-Country, ess ONLY required 1-12 who wish to plants brace, insulin pump, form completion is r MEDICATION	for students in Graay at the modified in prosthetic, sports gos	des 7 & 8 who wish aterscholastic sports agles, etc.):	to play at the s level.
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