HOLY TRINITY HIGH SCHOOL

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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:		DOB:	
Sex: □ Female □ Male		Grade	**Exam Date**
School:			

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

□ **Allergies**	Type: □Medication/Treatment Order Attached □ Anaphylaxis Care Plan Attached
□ **Asthma**	□Intermittent □ Persistent □ Other: □Medication/Treatment Order Attached □ Asthma Care Plan Attached
□ **Seizures**	Type: Date of last seizure: □Medication/Treatment Order Attached □Seizure Care Plan Attached
□ **Diabetes**	Type: □ 1 □ 2 □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

Percentile (Weight Status Category): □< 5th □ 5th- 49th □ 50th- 84th □85th- 94th □ 95th- 98th □ 99th and >

Hyperlipidemia: □ Yes □ Not Done **Hypertension:** □ Yes □ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	**Positive**	**Negative**	**Date**	**Lead Level** Required for PreK & K	**Date**
TB- PRN	□	□			
Sickle Cell Screen-PRN	□	□		□Test Done □ Lead Elevated >=5 µg/dL	

□**System Review Within Normal Limits**

□**Abnormal Findings** – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

□HEENT	□Lymph nodes	□Abdomen	□Extremities	□Speech
□Dental	□Cardiovascular	□Back/Spine/Neck	□Skin	□Social Emotional
□Mental Health	□Lungs	□Genitourinary	□Neurological	□Musculoskeletal

□Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
□ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:		DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** □Yes □ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	□Yes	□
Near Vision Acuity		20/	20/		□
Color Perception Screening	□ Pass □ Fail				□

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000Hz.				**Not Done**
Pure Tone Screening	**Right** □ Pass □ Fail	**Left** □ Pass □ Fail	Referral □ Yes	□

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	□	□	□ Yes	□

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

□***Family cardiac history reviewed** – required for Dominic Murray Sudden Cardiac Arrest Prevention Act

□**Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

□Student is restricted from participation in:

□Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

□Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.

□Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

□Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: □ I □ II □ III □ IV □ V

□**Other Accommodations***: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

□Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
□Confirmed free of communicable disease during exam	□Record Attached □ Reported in NYSIIS

HEALTHCARE PROVIDER **STAMP & DATE**

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form to Your Child's School Health Office When Completed.