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.

Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ **DOB:** _____

Grade: _____ **Teacher/HR:** _____ **School:** _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

1. **Name of Medication:**

   _____

2. **Name of Medication:**

   _____

3. **Name of Medication:**

   _____

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

Email: _____

Phone Where We Can Reach You: _____ ☐ **Check if Cell**

Return to:

School Nurse: _____

School Address: _____ Fax _____

Phone: _____ Email: _____

Rochester City School District
Student Health Services

PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Student: _____ Date of Birth: _____

The Rochester City School District now requires an ICD-10 diagnosis code for billing to support the medication order.

ICD-10 Diagnosis Code: _____

Diagnosis: _____

Medication: _____ Dose: _____ Route: _____
Ex. 15 mg (not number of units/tabs)

Time during school: _____ (Example: during lunch, before lunch, before gym)
(If you must specify a time, please limit hours to 10:00 am to 1:00 pm, except pm medications...
Parents/guardians should administer before –school or after-school medications).

Intended effects: _____ Restrictions: _____

Conditions under which to administer prn medications: _____

Other medication being taken (ON REVERSE):
Indicate if you have provided additional information as an attachment or on the reverse of this form.

Date: _____ Prescriber's Signature: _____ Phone: _____

Print Prescriber's Name: _____ FAX Number: _____ NPI#: _____

The spaces below are optional. Please carefully consider the appropriateness of this request.

Health Care Provider Permission For Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Signature: _____ **Date:** _____

PARENT PERMISSION For Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

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

STUDENT ACCEPTANCE OF RESPONSIBILITY

I will carry and/or store my medication in a responsible manner. I will take it as directed and will not allow others to use the medication. I will visit the nurse once each year for an update on how things are going.

Date: _____ **Student Signature:** _____

PLEASE RETURN THIS FORM TO:

ROCHESTER CITY SCHOOL DISTRICT
School Health Services
131 West Broad Street
Rochester, New York 14614

A Community of Learning

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (HIPAA)

Student Name _____ Birthdate: _____

Healthcare provider (doctor)_____ Phone: _____

Address _____ Fax: _____

Healthcare provider (doctor)_____ Phone: _____

Address _____ Fax: _____

☒ **Monroe County Health Dept. Clinics**

☒**Lead Testing** ☒**TB Clinic** ☒**Immunization Clinic** ☐**Other** _____

I hereby authorize my/my child's physician(s) listed above to exchange the following information with Rochester City School District, including:

☐ **All**

Or Specified:

☐ School nurse
☐ Medical officer
☐ Physical Therapist
☐ Occupational Therapist
☐ Speech Therapist
☐ Audiologist
☐ Vision Department
☐ Special Education
☐ Other _____

☐ Immunizations to comply with NYS regulations
☐ Physical exams to comply with NYS regulations and sports requirements
☐ Authorization for medications during the school day or on school trips
☐ Medical clearances as needed following an injury or change in condition
☐ Medical orders required for therapy needs, evaluations
☐ Physician referral for services (OT, PT)
☐ Medical condition/ treatment plans that may have an impact in school
☐ Other _____

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon signing this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. Positive results on lead testing are shared on a need to know basis between the health services and the educational team to develop suitable programming to address any problems associated with high lead levels.

This release expires on the last day of the enrollment of the above student in the Rochester City School District, and may be revoked at any time by sending a written and signed request to cancel this permission to the address above. Such revocation will not affect any disclosure made prior to its receipt by the District. Protected health information will not be disclosed without consent pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and implementing regulations (34 C.R.F. § 99). **A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the Rochester City School District by the healthcare providers listed above.**

_____ _____
(Signature of student over 18 or Parent/Guardian)** (Date)

If student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, state authority to act on student's behalf: _____. If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act and the information requested pertains thereto, then the parent/guardian must also sign consent form.

Return completed form to the NURSE at the school this child attends.