

## Alfred-Almond Central School

### STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, Interscholastic Sports and Working Papers.

Name:	DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Grade:	Exam Date:

#### IMMUNIZATIONS

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

<input type="checkbox"/> <b>Asthma:</b> <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent	<input type="checkbox"/> Asthma Action Plan Attached
<input type="checkbox"/> <b>Diabetes:</b> <input type="checkbox"/> Type I <input type="checkbox"/> Type 2 <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes Medical Mgmt Plan Attached
<input type="checkbox"/> <b>Seizures</b> Type: _____ Last Occurrence: _____	<input type="checkbox"/> Emergency Care Plan Attached
<input type="checkbox"/> <b>Allergies:</b> <input type="checkbox"/> Non Life-Threatening <input type="checkbox"/> Life-Threatening	<input type="checkbox"/> Emergency Care Plan Attached 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: _____ Allergen(s): _____	

<input type="checkbox"/> Hx of Anaphylaxis: Last occurrence: _____	Previous symptoms: _____
Treatment prescribed: <input type="checkbox"/> None <input type="checkbox"/> Antihistimine <input type="checkbox"/> Epinephrine Autoinjector	

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision one eye only  One functioning kidney  One testicle  Concussion - Last occurrence: \_\_\_\_\_

#### PHYSICAL EXAMINATION

Height:	Weight:	BP:	Pulse:	Respirations:																												
<b>Scoliosis:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive Degree of deviation: _____  Angle of trunk rotation via scoliometer: _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Vision</th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> <th style="width: 30%;">Referral</th> </tr> </thead> <tbody> <tr> <td>Distance acuity</td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Distance acuity with lenses</td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Vision - near vision</td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Vision - color perception</td> <td><input type="checkbox"/> Pass</td> <td><input type="checkbox"/> Fail</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <th style="text-align: center;">Hearing</th> <th style="text-align: center;">Right</th> <th style="text-align: center;">Left</th> <th style="text-align: center;">Referral</th> </tr> <tr> <td><input type="checkbox"/> 20 db sweep screen both ears or</td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>			Vision	Right	Left	Referral	Distance acuity			<input type="checkbox"/> Yes <input type="checkbox"/> No	Distance acuity with lenses			<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision - near vision			<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision - color perception	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing	Right	Left	Referral	<input type="checkbox"/> 20 db sweep screen both ears or			<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Weight Status Category (BMI Percentile):</b> <input type="checkbox"/> <5th <input type="checkbox"/> 85 <sup>th</sup> - 94 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> - 49 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> - 98 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> - 84 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> & higher																																

**Developmental Stage:** Tanner:  I  II  III  IV  V

SYSTEM REVIEW AND EXAM ENTIRELY NORMAL  Additional information attached  
 Specify any abnormalities: \_\_\_\_\_

## Alfred-Almond Central School

### RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

**Full Activity** without restrictions including Physical Education and Athletics.

**Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

**No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling

**No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton  **Other Specific Restrictions:**

<b>Accommodations / Protective Equipment:</b>	<input type="checkbox"/> Athletic Cup	<input type="checkbox"/> Insulin Pump/Insulin Sensor	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Brace/Orthotic	<input type="checkbox"/> Medical /Prosthetic Device	<input type="checkbox"/> Sports Safety Goggles
	<input type="checkbox"/> Hearing Aides	<input type="checkbox"/> Other:	

### PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

**Independent Carry and Use 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 along with parent/guardian permission to allow this option in schools.

**Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

### REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

**Parent/Guardian Permission:** I request the school nurse give the medications 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 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 date below.**

Medical Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Name: (please print) \_\_\_\_\_

Phone #: (     ) \_\_\_\_\_

Provider Address: \_\_\_\_\_

Fax #: (     ) \_\_\_\_\_

### Return to:

Karleigh Ormsby, RN  
 School Nurse  
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 Almond, New York 14804  
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