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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

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	☐	☐		☐ 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)

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	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 & 8000 Hz.				**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 Dominick 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

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

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

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2023-2024**
BRIARCLIFF MANOR, NY 10510

OVER THE COUNTER MEDICATION PERMISSION

Student's Name: _____ **Date:** _____

Allergies: _____ **Date of Birth:** _____

The following medications will be provided by The Clear View School Day Treatment Center if they have been approved by the child's physician/provider (signature is required) and requested by the guardian. Please indicate permission by checking Yes or No next to each medication name.

Yes/No	Medication Name	Route	Dosage & Schedule	Indications	Comments
☐yes ☐no	Tylenol (or generic, acetaminophen)	PO (chewable, elixir or tabs)	Per label instruction by age/weight	Pain or fever	Call parent/guardian in event of fever
☐yes ☐no	Advil (or generic, ibuprofen)	PO (chewable, elixir or tabs)	Per label instruction by age/weight	Pain or fever	Call parent/guardian in event of fever
☐yes ☐no	Benadryl (or generic)	PO (elixir or tabs)	Per label instruction by age/weight	Allergic reactions (hives, insect bites)	Call if allergic reaction, respiratory problems
☐yes ☐no	Cepacol lozenges (or generic; contains benzocaine)	PO	Per label instruction by age/weight	Sore throat	Check allergy history
☐yes ☐no	Tums (or generic, calcium carbonate)	PO (chewable)	Per label instruction by age/weight	Indigestion, heart burn	
☐yes ☐no	Pepto Bismol (or generic)	PO (chewable, elixir or tabs)	Per label instruction by age/weight	Upset stomach, nausea, diarrhea, indigestion	
☐yes ☐no	Oragel/Anbesol (or generic; contains benzocaine)	PO	Per label instruction by age/weight	Toothache, sore gums, canker sore	Check allergy history
☐yes ☐no	Hydrocortisone Cream 1%	Topical	Per label instruction by age/weight	Allergic reactions (contact dermatitis, insect bites)	
☐yes ☐no	Calagel	Topical	Per label instruction by age/weight	Poison ivy, poison oak	
☐yes ☐no	Medicaine Sting Swabs (or generic; contains benzocaine)	Topical	Per label instruction by age/weight	Insect bites, bee stings	
☐yes ☐no	Benadryl lotion (or generic)	Topical	Per label instruction by age/weight	Insect bites	
☐yes ☐no	Antibiotic ointment	Topical	Per label instruction by age/weight	Superficial cuts / abrasions	Check allergy history
☐yes ☐no	Saline eye drops	Liquid in eye	Per label instruction by age/weight	Dry eye / foreign body	
☐yes ☐no	Zyrtec	PO	Per label instruction by age/weight	Allergies	
☐yes ☐no	Lanacane	Topical	Per label instruction by age/weight	Sunburn, cuts / abrasions	
☐yes ☐no	Cough drops	PO	Per label instruction by age/weight	Sore throat / cough	

Physician/Provider Signature: _____ Date: _____

Physician/Provider Stamp (required):

Parent/Guardian Signature: _____ Date: _____

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IMMUNIZATION RECORD

Fill in the age and date for each immunization student has received.

Student's Name: _____ Date of Birth: _____

Hepatitis B	#1	#2	#3		
Age:					
Date:					
DTaP (Tetanus)	#1	#2	#3	#4	#5
Age:					
Date:					
Tdap	#1				
Age:					
Date:					
Hib	#1	#2	#3		
Age:					
Date:					
IPV (OPV)	#1	#2	#3	#4	
Age:					
Date:					
MMR	#1	#2			
Age:					
Date:					
Varicella	#1	#2			
Age:					
Date:					
Pneumonia PCV	#1	#2	#3	#4	
Age:					
Date:					
Meningitis MCV4	#1	#2			
Age:					
Date:					
Influenza	#1				
Age:					
Date:					
H1N1	#1				
Age:					
Date:					
HPV	#1				
Age:					
Date:					
PPD	#1				
Age:					
Date:					
COVID-19	#1	#2	Booster	Booster	
Age:					
Date:					
Other					
Age:					
Date:					

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2023-2024**
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ANNUAL DENTAL EXAMINATION

Student's Name: _____ Date of Birth: _____

Address: _____

Date of Examination: _____

TEETH

General Condition _____

Temporary _____

Permanent _____

Carious _____

GUMS

General Condition _____

This patient:

- ☐ requires no dental treatment at this time
- ☐is under dental treatment at this time
- ☐will begin dental; treatment at this time
- ☐has completed all current dental treatment

REMARKS OR RECOMMENDATIONS:

Dentist Signature: _____

Date: _____

Address: _____

Phone Number: _____