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**	Type: ☐ 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 Type: ☐ 2	
	☐ Medication/Treatment Ordered Attached	☐ Diabetes Medical Management Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History 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 ☐ No ☐ 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:	Diagnoses/Problems (list): ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for New Entrants, 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/	☐ Yes	☐
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 Required for Boys grade 9 and Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐	☐

Notes:

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

☐ **Family cardiac history reviewed** – required for sports (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, or Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, or Volleyball
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.
- ☐ **Other Restrictions:**

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the 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 **2026 - 2027**
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	Orageel/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: _____

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2026 - 2027**
BRIARCLIFF MANOR, NY 10510

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:					

2026-27 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the **ACIP-Recommended Child and Adolescent Immunization Schedule.** Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Child Caring Center, Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose** given at age 10 years or older	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses** or **2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose** given at age 10 years or older	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

   *Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
   d. For further information, refer to the Catch-Up Guidance for Children 4 Months through 6 Years of Age.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 12: 10 years).
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap given at age 10 years or older.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
   d. For further information, refer to the Catch-Up Guidance for Children 7 through 9 Years of Age.
   e. For further information, refer to the Catch-Up Guidance for Children 10 through 18 Years of Age.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age:
   6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward New York State school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.
   e. For further information, refer to the Catch-Up Guidance for Children 4 months through 18 Years of Age.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: One dose is required for pre-kindergarten. One dose is required for grades kindergarten through 12.

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 12: 10 years).
   a. One dose of meningococcal conjugate vaccine is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age:
   6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.
   f. For further information, refer to the Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age (PedvaxHIB only).
   g. For further information, refer to the Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age (ActHIB, Hiberix, Pentacel, Vaxelis, or Unknown).

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
    a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
    b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
    c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
    d. If one dose of vaccine was received at 24 months or older, no further doses are required.
    e. PCV is not required for children 5 years or older.
    f. For further information, refer to the Catch-Up Guidance for Children 4 months through 4 Years of Age. *Depending on vaccine brand, schedule may change.

For further information, contact:

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Division of Vaccine Excellence
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Albany, NY 12237
(518) 473-4437
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