SWEET HOME CENTRAL SCHOOL DISTRICT
PARENT PERMISSION FOR PHYSICAL EXAMINATION

HF-1f
Rev. 1/00

Dear Parent/Guardian:

Physical examinations are required by the Sweet Home Central School District according to the New York State School Health Law (Section 903). The following students are required to have a physical examination:

- ✓ All new entrants to the district, regardless of grade level.
- ✓ Students in Grades Pre-K, K, 1, 3, 7, 10. and 5
- ✓ Special Education students are required to have a physical examination complete with a neurological screening upon initial placement and every three years as needed.

- ✓ Please note- All students participating in a sport activity at the Middle School or Senior High School will have a sport physical in school by our school physician.

The "Student Physical Examination" report form is available if the examination is to be given by your Primary Health Care Provider. This form should be returned to us as soon as possible. The physical examination must to be given by a New York State Health Care Provider and it needs to be current (after June of the current school year.) Please inform us if your child has had an exam, or if an appointment is scheduled with your Health Care Provider for a physical examination at the beginning of the school year.

Your child will be scheduled for a school physical if the "Student Physical Examination" report is not returned to the Health Office by the time school physicals begin in early Fall, or by the date noted in the box below.

You may contact the health office personnel if you have any questions or concerns. Thank you.

Please ☑ check the appropriate box below, sign your name, and return this completed form to your child's school Health Office by the **first week of school** unless otherwise noted below*.

- ☐ I have already submitted an examination form from my child's Health Care Provider.
  Exam was given on (date)_____by (name) _____.
- ☐ My child is scheduled for a physical examination by our Health Care Provider on
  (date)_____by (name) _____.
  I will return the completed physical examination health form as soon as possible.
- ☐ My child may receive a school physical examination by the School Nurse Practitioner and/or School Physician.

Student Name: _____ **Grade/Teacher:** _____

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

* Please complete and return this form to the Health Office by _____.

St. Christopher's School, Health Office
2660 Niagara Falls Blvd.
Tonawanda, NY 14150

Instructions for Completion of New York State School Health Examination Form

This form is to be completed in its entirety, except fields designated as optional, by the private provider or school medical director. NYSED requires a physical exam for new entrants and students in grades pre-K or K, 1, 3, 5, 7, 9, and 11; annually for inter-scholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-school special education (CPSE). The date of examination must be not more than 12 months prior to the start of the school year and noted on form.

Health History

Chronic medical conditions should be listed in patient's problem list.

- ICD-10 codes should accompany diagnoses ONLY for patients who have Medicaid and have an Individualized Education Plan (IEP) for special education in school and receive related services (i.e. nursing, social worker/psychologist, PT/OT/ST, or special transportation).
- Asthma, Seizure disorders, life threatening allergies and Diabetes must be included if diagnosed, and each require a separately attached care plan:
    - Diabetes- requires a Diabetes Medical Management Plan (DMMP) specifying the type of diabetes and most recent hemoglobin A1c (include date), See NYSDOH Diabetes Medical Management Plan;
    - Seizure disorders care plans should include date of last known seizure; See NYSCSH Seizure ECP with Medication Information ;
      Asthma - Asthma Action Plans should include medication orders along with directives. See NYSDOH Asthma Action Plan; and
    - Allergies - life threatening allergy care plans should specify what the patient is allergic to. See AAAI Sample Anaphylaxis Emergency Action Plan .
- Consider screening for T2DM if BMI% >85% and child has 2 or more risk factors: Family history of T2DM, Ethnicity, Symptoms of insulin resistance, History of gestational diabetes in the mother, and or pre-diabetes.
- Include hyperlipidemia and hypertension if diagnosed.
- Include mention of unpaired eye, kidney or testicle if relevant.
- Include mental health diagnoses where permitted by patient/family.
- Under allergies, List all allergies including medication, food, insects, latex, and other environmental allergens.
- Attach medication administration forms for medication which will be administered in school
- Past medical history must include any concussions with the dates of when they occurred.
- Height, weight, and BMI must be provided including percentile for each, as well as marking appropriate BMI category.
- Pulse and respiratory rate are to be documented for students with diagnosed respiratory or cardiac conditions.

Laboratory and Diagnostic Testing

- Tuberculosis screening, if indicated and performed, should specify type of testing (PPD or Interferon-gamma release assay), result, and test date.
  Screening for vision and hearing in grades PreK or K, 1, 3, 5, 7, and 11, and for scoliosis in grades 5 and 7 for girls, grade 9 for boys that is not done or reported on the school form will be performed by the school.
- Vision screening should include the results of distance acuity testing in each eye (pass is 20/30 or better), an assessment of near vision acuity (pass is 20/40 or better). Color vision (pass/fail) is required if student is attending a new school. See NYSED Vision Screening Guidelines for Schools
- Hearing screening should be performed at 20 db and pass or fail noted for each frequency (500Hz, 1000Hz, 2000Hz, 4000Hz); children ≥11 years of age should be screened for high frequency hearing loss by testing at 6000Hz and 8000Hz. See NYSED Hearing Screening Guidelines for Schools
- Lead screening- indicate if screening done for students in PreK or K.

Physical Examination

- A complete physical exam must include the following systems: HEENT, Dental, Neck, Lymph nodes, Lungs, Abdomen, Back/Spine including screening for scoliosis (see above grade levels), Genitourinary, Extremities, Skin, Neurological, Speech/Language, Social-Emotional, and Musculoskeletal.
- Abnormal findings on review of systems and physical exam should be noted
- Tanner Staging (1-5) must be supplied ONLY for any student in Grades 7 or 8 to play sports at a high school level or Grades 9-12 to play middle school level sports.

Assessment and Recommendations

- State has no restrictions if applicable
- Please note any restrictions on physical activity including participation in physical education, sports, playground and work. Include applicable limitations on contact sports - baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling, non-contact sports- archery, badminton, bowling, cross country, fencing, golf, gymnastics, riflery, skiing, swimming and diving, and track & field, or other specific restrictions.

- List any accommodations required for participation including but not limited to: Brace/Orthotic, Insulin pump/sensor, Protective equipment, Colostomy appliance, Medical/Prosthetic device, Sport safety goggles, Hearing aids, Pacemaker/Defibrillator, etc. Specific approval and associated documentation may be required if use of device will occur during athletic competitions, please check with athletic governing body for more information.
- Chronic medications should be listed- medication strength/concentration, formulation, dose, frequency, and timing should be noted for those medications to be administered during the school day.
- Providers may attach an immunization form or refer to NYSIIS registry if record available and complete.
- Referrals, such as those for abnormalities on vision or hearing screening should be noted.
- Please include any additional information that may be useful to the school that is not otherwise solicited.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ 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*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
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 ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

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

☐ **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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, Pre K or K, 1, 3, 5, 7, 9, and 11.. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle		
Birth Date: / / Month Day Year	Sex: ☐ Male ☐ Female	Will this be your child's first visit to a dentist? ☐ Yes ☐ No
Name of School:		Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?
☐Yes ☐No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.
I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent/Guardian Name_____
Parent/Guardian Signature_____ Date _____

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (Date of Exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:
☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.
NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (Please print or stamp):	Dentist's Signature:

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).
☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
☐ Yes ☐ No Dental Sealants Present
Other problems
Specify)_____

III. Treatment Needs (check all that apply)
☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.