Fort Plain Central School

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider of school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ Date of birth: _____ Gender: __ M __ F

School: Fort Plain Junior/Senior High School Grade: _____ ___ NA Exam Date: _____

HEALTH HISTORY

Specify Current Diseases

O Asthma (O intermittent or O persistent)
Quick relief inhaler: O Yes O No
Asthman Action Plan: O Yes O No
O Type 1 Diabetes
O Type 2 Diabetes
O Hyperlipidemia
O Hypertension
O Other: _____

Sickle Cell Screen	O Positive	O Negative	O Not Done	Date: ____
PPD	O Positive	O Negative	O Not Done	Date: ____
Elevated Lead	O Yes	O No	O Not Done	Date: ____
Dental Referral	O Yes	O No	O Not Done	Date: ____

O Alleries - See Page 2 for Details

Significant Medical/Surgical information:

PHYSICAL EXAMINATION

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respirations: _____

Scoliosis: O Negative O Poisitve
Degree of deviation: _____
Angle of trunk rotation via scoliometer: _____

Body Mass Index
Weight Status Category (BMI Percentile)
O <5th O 85th - 94th
O 5th-49th O 95th - 98th
O 50th-84th O 99th & higher

Vision	**Right**	**Left**	**Referral**
Distance acuity			Y N
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	Pass	Fail	
Hearing	**Right**	**Left**	**Referral**
20db sweep screen both ears or			Y N

Circle evelopmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: I II III IV V

O SYSTEM REVIEW AND EXAM ENTIRELY NORMAL O See attached
Specify and abnormalities

Name: _____ Date of Birth: _____

Recommendations or restrictions for participation in physical education/sports/playground/work

O Free from contagions and physically qualified for all activites (Phys. ed., athletics, playground, work, school)
O Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball
O Strenuous: cross-country, gym nastics, track & field, swim, diving, crew, ski, cheering, tennis, bad minton, fencing
O Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walki ng
O Protective Equipment: O Athletic Cup O Sport/safety goggles OOther:
O Medical/prosthetic device:
O Recom mendations/restrictions:

MEDICATIONS

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/Self Carry **

* Self Directed: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, time, and effect, of taking or not taking the medication, cane recognize the medication and refuse to take it inappropriately, and can ingest, in hale, apply or calculate and administer the correct dose of the medication independently.

** Self Admin/Self-Carry: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition give them permission to self-carry and self administer this medication. They will be considered independent in medication delivery and need intervention only in emergencies.

To be completed by Parent/Guardian if medication is prescribed

O I give permission for the above medication to be administered to my child as ordered by my health care provider. will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: _____ Date: _____ Phone: _____

O Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered.

Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature:_____ Date: _____ Phone: _____

ALLERGIES

O None O Non Life-Threatening O Likfe Threatening

Type: O Food O Insect OLatex O Medication O Seasonal/Environmental O Other

Specify allergen(s): _____

_____

Specify previous symptoms: _____

O History of anaphylaxis; last occurance: _____

Emergency Care Plan for anaphylaxis: O Yes O No

Treatment prescribed: O None O Antihistimine O Epinephrine Autoinjector

IMMUNIZATIONS

O Immunization Record Attached

O Immunizations reported to NYSIIS

O No immunizations recieved today

O Immunizations recieved today:

O Will return on _____ to recieve: _____

PROVIDER/PARENTAL AUTHORIZATION

All information contained herein is valid through th last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name (Please Print): _____

Provider Address: _____

Phone Number: _____ Fax Number: _____ Email: _____

Parent/Guardian Signature: _____

Return to:

School Nure: Tara Hayes, RN, tara.hayes@fortplain.org
School: Fort Plain Jr./Sr. High School
Phone: (518) 993-4000 ext. 2122
Fax: (518) 993-2897
Date: _____