



PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE)

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____ Date of Physical Examination: _____

IMMUNIZATIONS/HEALTH HISTORY

- | | |
|--|---|
| <input type="checkbox"/> Immunization record attached
<input type="checkbox"/> No immunization given today
<input type="checkbox"/> Immunizations given since last Health Appraisal: | Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____
PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____
Elevated Lead: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____
Dental Referral: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ |
|--|---|

Significant Medical/Surgical History: See attached _____

- Specify Current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other _____
- Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ . _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th – 49 th <input type="checkbox"/> 50 th – 84 th <input type="checkbox"/> 85 th – 94 th <input type="checkbox"/> 95 th – 98 th <input type="checkbox"/> 99 th + higher				Referral
Vision – without glasses/contact lenses	R	L		
Vision – with glasses/contact lenses	R	L		
Vision – Near Point	R	L		
Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L		

EXAM ENTIRELY NORMAL Tanner: I. 11. 111. 1V. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____
 Name: _____ Dosage/Time: _____

- I assess this student to be self-directed Yes No
 Student may self carry and self administer medication Yes No
 Student may self carry and self administer medication on a field trip Yes No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION/CSE CONSIDERATION

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:** _____ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball
 _____ Non-contact: badminton, bowl, golf, swim, table tennis, archery, weight train, crew, dance, track, run, walk, rope jump
- Specify medical accommodations needed for school:** _____ None
- Known or suspected disability:** _____
- Restriction:** _____
- Protective equipment required:** Athletic Cup Sport goggles/impact resistant eyewear Other: _____

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

SYRACUSE CITY SCHOOL DISTRICT
725 Harrison St.
Syracuse, New York 13210

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HEALTH SERVICES

Dear Parents of _____:

It is required by the New York State Health Department that each student have a physical examination upon initial entrance, new to the school district, and routinely at grades K, 2, 4, 7, and 10. A medical examination is also required for organized interscholastic athletic activities and/or a working paper permit. It is suggested that these be done by the family physician, the one who best knows the child. The family physician is better able to judge any change or deviation in the child's state of health. Findings can be discussed and referrals (i.e., eye glasses) can then be made all in one visit. The School Physician/Nurse Practitioner examination includes:

- Review of Health History
- Head, Eyes, ears, nose, throat, neck and lymph nodes
- Examination of heart and lungs
- Palpation of the abdomen
- Strength and range of motion of arms and legs
- Neurological examination, reflex, balance coordination
- Scoliosis (curvature of the spine)
- Any bony abnormality or injury
- Male examination of penis, scrotum, testes and developmental stage,
Presence/absence of hernia
- Self-rating of Breast development and pubic hair and menstruation in females

These recommendations are based on New York State Health Department requirements.

Your child is scheduled to be examined _____.

Please check one of the boxes below and return this form to the school health office by _____.
(Date)

- I give permission for my child to receive his/her physical exam in school
- I will provide a physical exam by my own provider scheduled on _____.
(Date)

For further information, please contact your school nurse or the Health Services Office at 435-4145.

In all cases where this form is not returned, the school provider will proceed with the physical examination per New York State law. Your child may refuse the examination. In that case you will be required to obtain the examination by your own provider. They will not be rescheduled.

Student's Name

Signature of Parent/Guardian

School

Date