REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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 — ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type — ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ 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

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

ALLEGANY-LIMESTONE CENTRAL SCHOOL

3131 Five Mile Road •Allegany, NY 14706

District Office
Phone: 716-375-6600
Fax: 716-375-6629

Middle/High School
Ext. 2110/2100
Fax: 716-375-6630

Elementary School
Ext. 4172
Fax: 716-375-6628

Special Education
Ext. 4164
Fax: 716-375-6601

Bus Garage
Ext. 6612
Fax: 716-375-6627

Dear Parent/Guardian:

The school district has provided student accident insurance for your child as a member of our district. This coverage provides payment for medical expenses due to accidental injury while attending school, traveling to and from school, or participating in school sponsored activities.

Student accident insurance is "excess" coverage. This means that your family's health insurance is primary, and you must submit all claims to your insurance first. It also means that you must follow the rules of your primary carrier. The school insurance plan is not an alternative to your regular health insurance. The student accident policy is to cover any out-of-pocket expenses, such as co-payments and deductibles. If your family does not have health insurance, the school's policy will act as primary, but be aware the carrier may ask you for proof, such as a letter from your employer or your Medicaid Card, if applicable.

If your family does not have health insurance coverage, New York State has a program called Child Health Plus, which is available to all New York state residents. You can reach them at 1-800-698-4KIDS.

HOW TO FILE A CLAIM: ***Please don't send the forms back to school.***

- **The school completes part A.**
- **Parent/Guardian completes Part B.**
- **Submit the Claim Form within 90 days of the accident to Commercial Travelers address below.**
- **Submit appropriate documentation. NOTE: If you are receiving treatment from a provider (primary care physician), please request a CMS 1500. If you are receiving treatment from a hospital, please request a UB04.**
- **Please submit any Notice of Payment or Rejection (EOB or explanation of benefits) from your health insurance carrier. Any itemized billing statements submitted must include a diagnosis code and procedure code.**
- **Please notify all physicians, hospitals or other healthcare providers that have or will be treating your child and provide them with these instructions. Have the providers to forward bills to:**

  Commercial Travelers Life Insurance Company
  Attn: K-12 Claim Administration
  70 Genesee Street, Utica NY 13502
  FAX: 315-797-0195

Allegany -Limestone Central School

3131 Five Mile Road · Allegany, New York 14706 www.alli.wnyric.org

APPENDIX D
SELF-MEDICATION RELEASE FORM
"Carry On-Self"

STUDENT NAME: _____

This student has been instructed in the proper use of the following medication procedures:

Medication Name: _____

We, (Physician Signature) _____

And (Parent/Guardian Signature) _____

Request that (Student) _____ be permitted to carry the medication on his/her person, or to keep same in his/her locker or gym locker, as we consider him/her responsible. He/she has been instructed in, and understands, the purpose and appropriate method and frequency of use.

NOTE: This form must be completed in addition to routine district medication form for those students who request permission to carry their own medication on campus or to keep this medication in a gym locker.

District Office
716-375-6600
Fax: 375-6629

Middle/High School
716-375-6600 Ext. 2110/2100
Fax: 375-6630

Allegany-Limestone Elementary
716-375-6600 Ext. 4172
Fax: 375-6628

Special Education
716-375-6600 Ext. 4164
Fax: 375-6601

Bus Garage
716-375-6612
Fax: 375-6627

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ALLEGANY-LINESTONE CENTRAL SCHOOL DISTRICT
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

1) To be completed by the parent or guardian

I request that my child,_____ DOB_____ GRADE_____
receive the medication as prescribed below by our physician.

The medication is to be personally delivered by me (parent or guardian) in the original labeled pharmacy container stating the specific name of the medication and dispensing orders, or we can use the health office stock bottles of medication.

Signature (Parent or Guardian): _____

Telephone: Home_____ **Work**_____**Date**_____

2) To be completed by physician

I request that my patient, as listed below, receive the following medication:

• **Acetaminophen** (see chart) orally, every 4 hours as needed for headache, fever, or pain.		
Child's Weight- lbs.	Dose- mg	**Parent/Guardian Initials for acetaminophen:**
60-95	325	
95 and over	650	
151 and over	May have up to 1000mg	
• **Ibuprofen** (see chart) orally, every 6 hours as needed for headache, fever, or pain.		
Child's Weight- lbs.	Dose- mg	**Parent/Guardian Initials for ibuprofen:**
48-95	200	
96 and over	400	
• **Rolaids or Tums** 1-2 tabs orally, every 2 hours as needed		
For heart burn, upset stomach.		**Parent/Guardian Initials for Rolaids or Tums:**

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____

Address:_____

Phone: _____

Date: _____