

## BINGHAMTON CITY SCHOOL DISTRICT REPORT OF MEDICAL EXAMINATION

**STUDENT HEALTH EXAMINATION FORM** (To be completed by private health care provider or 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. Weight status category data collection is REQUIRED by NYS. If you DO NOT WISH your child's data included you must inform the school nurse in writing.

Name:	DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
School:	Grade: <input type="checkbox"/> NA	Exam Date:

### HEALTH HISTORY

Specify Current Diseases	
<input type="checkbox"/> Asthma ( <input type="checkbox"/> Intermittent or <input type="checkbox"/> Persistent ) Quick relief inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma Action Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Other:	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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done    Date: Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done    Date:
	<input type="checkbox"/> Allergies - See page 2 for details.

Significant Medical/Surgical Information:

### PHYSICAL EXAMINATION

Height:	Weight:	BP:	Pulse:	Respirations:	
<b>Scoliosis:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive Degree of deviation: _____ Angle of trunk rotation via scoliometer: _____		<b>Vision</b>		<b>Right</b>	<b>Left</b>
				<b>Referral</b>	
		Distance acuity			<input type="checkbox"/> Yes <input type="checkbox"/> No
		Distance acuity with lenses			
<b>Body Mass Index:</b>		Vision - near vision			
Weight Status Category (BMI Percentile):		Vision - color perception		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
<input type="checkbox"/> <5th <input type="checkbox"/> 85 <sup>th</sup> - 94 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> - 49 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> - 98 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> - 84 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> & higher		<b>Hearing</b>		<b>Right</b>	<b>Left</b>
		<input type="checkbox"/> 20 db sweep screen both ears or			<b>Referral</b>
					<input type="checkbox"/> Yes <input type="checkbox"/> No

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

SYSTEM REVIEW AND EXAM ENTIRELY NORMAL                       See attached  
 Specify any abnormalities:

Name:

DOB:

**MEDICATIONS**

**To be completed by Health Care Provider**

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, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, 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 during emergencies.

**To be completed by Parent/Guardian if medication is prescribed**

I give permission for the above medication to be administered to my child as ordered by my health care provider. I 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: ( ) \_\_\_\_\_

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**

None                       Non Life-Threatening                       Life-Threatening

Type: Food Insect Latex Medication Seasonal/Environmental Other:

Specify allergen(s):

Specify previous symptoms: \_\_\_\_\_ History of anaphylaxis; last occurrence:

Emergency Care Plan for anaphylaxis: Yes No

Treatment prescribed: None Antihistimine Epinephrine Autoinjector

**IMMUNIZATIONS**

Immunization record attached                       Immunizations received today:  
 Immunizations reported on NYSIIS  
 No immunizations received today                       Will return on: \_\_\_\_\_ to receive:

**Provider / Parental Authorization**

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

Medical Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Name: (please print) \_\_\_\_\_ Phone #: \_\_\_\_\_

Provider Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Provider Email: \_\_\_\_\_

**Return this form to your child's school nurse by October 1<sup>st</sup>. If this form is not returned by October 1<sup>st</sup> your child will be scheduled for a physical in school.**