MAMARONECK UNION FREE SCHOOL DISTRICT

STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: ____________________ DOB: ____ Gender: ☐M ☐F

School: ____________________ Grade: **Exam Date:** ________

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma:** ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes:** ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures** Type: ____________________ Last Occurrence: __________ ☐Emergency Care Plan Attached

☐**Allergies:** ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Allergen(s):

☐Hx of Anaphylaxis: Last occurrence:__________ Previous symptoms: ____________________

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

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

Scoliosis: ☐Negative ☐Positive

Degree of deviation: ____________________

Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th

☐ 5th - 49th ☐ 95th - 98th

☐ 50th - 84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): **Tanner:** ☐I ☐ II ☐III ☐IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities:

Name: ______________________________ DOB: ______________

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

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

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

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

Accommodations / Protective Equipment:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	☐Pacemaker
	☐Brace/Orthotic	☐Medical /Prosthetic Device	☐Sports Safety Goggles
	☐Hearing Aides	☐Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

______________________ ______________________

______________________ ______________________

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

☐ **Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature:

HEALTH CARE PROVIDER

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 #: (   ) ______________

Return to:

School Nurse: ______________________ School: ______________

Phone #: (   ) Fax: (   ) Date:

MAMARONECK UNION FREE SCHOOL DISTRICT
VACCINATION ADMINISTRATION RECORD

Please return this report to your **School Nurse** as soon as your child's vaccinations have been given and/or updated. Obtaining proper vaccinations for your child is required by law and admission to school can be **denied** without them. Vaccines must follow the Advisory Committee for Immunization (ACIP) guidelines.

This form should be completed and/or updated annually. Please see the list of immunization requirements below:

NAME: ______________________ **DATE:** ______________

DOB: ______________ **GRADE:** ______ **TEACHER/COUNSELOR** ______________

School: ○ CEN ○ CHAT ○ MAS ○ MUR ○ HMX ○ HS ○ Other: ______________

Immunization Requirements:

As required by NY State Dept. of Education, Health Care Provider verification of the following is needed for school attendance:

- **DTaP : three - five (3-5) doses** of diphtheria and tetanus toxoid-containing vaccine and acellular pertussis vaccine
- **Tdap : one (1)dose** - students 11 years of age or older entering grade 6 through 12 are required to have one dose of Tdap
- **IPV : three – four (3-4) doses** of polio vaccine
- **MMR : two (2) doses** of live measles, mumps and rubella vaccine (K-12)
- **HBV : three (3) doses** of Hepatitis B vaccine at intervals recommended by the ACIP
- **VARICELLA: – two (2) doses** of Varicella (chicken Pox) entering kindergarten, Grade 1, Grade 6 and Grade 7

In addition, for pre-kindergartners:

- **Hib** Haemophilis influenzae type b vaccine: 1-4 doses
- **PCV** Pneumococcal conjugate (**PCV**) 1-4 doses (age appropriate)

VACCINATION ADMINISTRATION RECORD
TO BE COMPLETED & SIGNED BY THE HEALTH CARE PROVIDER

VACCINE DATE GIVEN:

DTaP 1 ______________ DTaP 3 ______________

DTaP 2 ______________ DTaP 4 ______________

DTaP 5 ______________ OR…

DT 1 ______________ OR Td 1 ______________

DT 2 ______________ OR Td 2 ______________

DT 3 ______________ OR Td 3 ______________

Tdap ______________

IPV 1 ______________ IPV 3 ______________

IPV 2 ______________ IPV 4 ______________

VARICELLA 1 ______________

VARICELLA 2 ______________

MMR 1 ______________

MMR 2 ______________

TST (LAST) MANTOUX ______________ RESULT ______________ ❖

BCG ______________

❖ If Positive TST, Chest x-ray needed:
Date of CXR: ______________ Results: ______________
INH started: ______________ X ______________ months

VACCINE DATE GIVEN:

HEP B 1 ______________

HEP B 2 ______________

HEP B 3 ______________

OR (Adult formulation 2 dose series, ages 11 – 15 yrs)

HEP B 1 (1.0 ML) ______________

HEP B 2 (1.0 ML) ______________

HIB 1 ______________

HIB 2 ______________

HIB 3 ______________

HIB 4 ______________

PNEUMOCOCCAL VACCINE

1 ________ 2 ________ 3 ________ 4 ________

MENINGOCOCCAL VACCINE ______________

HEP A 1 ______________ HEP A 2 ______________

HUMAN PAPILLOMAVIRUS VACCINE (HPV)

1 ________ 2 ________ 3 ________

OTHER ______________

____

OFFICE STAMP NECESSARY HERE↓

Healthcare Provider
NAME (Print) ______________ SIGNATURE: ______________

ADDRESS: ______________ TELEPHONE #: ______________

CITY/STATE/ZIP: ______________ DATE: ______________

11/15