

**Sample Parent/Guardian Notification Regarding the Completion of
the Required School Health Examination Form Effective 1/31/2021**

Dear Parent/Guardian,

Date:

Education Law requires all New York State (NYS) public school students to have a health exam when they are a new student in a school district and when they enter Pre-K or Kindergarten, and grades 1, 3, 5, 7, 9, and 11.

Beginning on 1/31/21, schools cannot accept the health exam if it is not on the required form or the required health record equivalent.

We have attached a letter and copy of the required form with instructions for your health care provider (HCP). The form and instructions are also on our website at www.schoolhealthny.com. Please share the attached papers at your child's visit for a health exam with the health care provider (HCP). This is typically your doctor but may be a nurse practitioner or physician assistant.

Sincerely,

School District Medical Director/Administrator

If you have questions, please contact:

Nurse: _____ School: _____

Phone: _____ Fax: _____

Email: _____

Sample Health Care Provider Notification Regarding the Completion of the Required School Health Examination Form Effective 1/31/2021

Dear Health Care Provider,

Date:

Education Law requires all New York State (NYS) public school students to have a health exam as a new entrant and in Pre-K or Kindergarten and grades 1, 3, 5, 7, 9, and 11.

Effective 2/1/21, all health examinations performed for school must be documented on the NYS Required Health Examination Form or an electronic health record equivalent form - pursuant to Education Law. The form will be available on the NYSDOH Health Commerce System (HCS) in mid-February.

ONLY the approved form or an electronic health record equivalent form will be accepted by schools for health examinations conducted on or after 1/31/2021.

Students who present a physical exam that is not acceptable will be required to have the parent/guardian contact your office to complete the correct form. Students who are unable to obtain the correct form will be required to have the health examination repeated at school, which will upset many families. To prevent that, we ask that you comply with Education Law and document a health exam on the correct form or electronic health record equivalent.

Please note the components on the health exam form are required in NYS Law.

The Instructions for Completion of the New York State School Health Examination EHR Compatible Form provides direction to healthcare providers on the required components and the required presentation order of those components for an electronic health record form to be an equivalent form.

This information is also on the NYS Center for School Health website at www.schoolhealthny.com.

Thank you for assisting your patients and families by providing the documentation required by NYS Education Law.

Sincerely,

School Medical Director/Administrator

Please direct any questions to:

Nurse: _____ School: _____

Phone: _____ Fax: _____

Email: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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 Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$				

System Review and Abnormal Findings Listed Below

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:			DOB:	
SCREENINGS				
Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
Notes				
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes				
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Student may participate in all activities without restrictions.				
<input type="checkbox"/> Student is restricted from participation in:				
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.				
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.				
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.				
<input type="checkbox"/> Other Restrictions:				
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.				
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____				
<input type="checkbox"/> Other Accommodations* : (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIS				
HEALTH CARE PROVIDER				
Medical Provider Signature:				
Provider Name: <i>(please print)</i>				
Provider Address:				
Phone: Fax:				
Please Return This Form To Your Child's School When Completed.				