

**HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT**

**HIGH SCHOOL EAST**

**HEALTH OFFICE  
50 Vanderbilt Pkwy  
Dix Hills, NY 11746**

**June 2021**

Dear Parent/Guardian:

**The New York State Education Department** requires all students entering 9<sup>th</sup> grade to have a current physical examination on file at school. **The physical must be dated on or after September 1, 2020** and should be returned to the Health Office. Dental certificates may be submitted as well.

For your convenience attached is a physical exam form.

Thank you for your attention to this matter.

Diane Schebece, RN  
Cathy Blachly, RN  
School Nurses  
phone: (631) 592-3101 or 592-3127  
fax: (631) 592-3976 or 592-3977

**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**

<b>Allergies</b> <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
<b>Asthma</b> <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
<b>Seizures</b> <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:
<b>Diabetes</b> <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):** ☐ <5<sup>th</sup> ☐ 5<sup>th</sup>-49<sup>th</sup> ☐ 50<sup>th</sup>-84<sup>th</sup> ☐ 85<sup>th</sup>-94<sup>th</sup> ☐ 95<sup>th</sup>-98<sup>th</sup> ☐ 99<sup>th</sup> and >

**Hyperlipidemia:** ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns</b> (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"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$				
<input type="checkbox"/> <b>System Review and Abnormal Findings Listed Below</b>				
<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"/> <b>Assessment/Abnormalities Noted/Recommendations:</b>			<b>Diagnoses/Problems (list)</b> <span style="float:right"><b>ICD-10 Code*</b></span>	
<input type="checkbox"/> <b>Additional Information Attached</b>			*Required only for students with an IEP receiving Medicaid	



Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision</b> (w/correction if prescribed)	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
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					
<b>Hearing</b> 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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
<b>Scoliosis Screen</b> Boys in grade 9, and Girls in grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 &amp; 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.</b> <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <b>Age of First Menses (if applicable) :</b> _____					
<input type="checkbox"/> <b>Other Accommodations*:</b> (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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS					
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					

Towns of  
Huntington and Babylon

THIS IS TO CERTIFY THAT\_

- \_\_\_\_\_  
DENTIST'S SIGNATURE  
(TO BE SIGNED BY DENTIST AND RETURNED TO SCHOOL BY PUPIL)
- \_\_\_\_\_  
DATE

THE LOCAL DENTAL SOCIETIES HAVE PASSED THE FOLLOWING RESOLUTION.  
YOUR COOPERATION IS ESSENTIAL FOR THE PROTECTION OF THIS CHILD.

"RESOLVED: THAT IN NO CIRCUMSTANCE SHOULD A CERTIFICATE OF COMPLETION BE GIVEN TO THE CHILD OR PARENT UNLESS THE DENTAL SERVICE HAS BEEN ACTUALLY COMPLETED".

HAVE YOUR CHILD VISIT DENTIST AT LEAST ONCE EACH YEAR.

1. LOCATE TINY, HIDDEN OR UNSEEN CAVITIES, AND TREAT THEM BEFORE THEY BECOME BIG ONES.
2. DISCOVER INFLAMED GUMS.
3. EXAMINE FOR IRREGULARLY PLACED TEETH.

REGULAR DENTAL CARE, THE USE OF RIGHT KINDS OF FOODS, THE AVOIDANCE OF EXCESSIVE USE OF SWEETS, SUGAR, CANDY, AND SWEETENED DRINKS, THE BRUSHING OF TEETH AFTER MEALS OR RINSING THE MOUTH WHEN BRUSHING IS NOT POSSIBLE, WILL HELP YOUR CHILD'S TEETH.