Miller Place Union Free School District Health Examination Form

Note: NYSED requires a physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10

Miller Place HS
15 Memorial Drive
Miller Place, NY 11764
Health Office 631-474-2481
Fax: 631-331-4093

North Country Rd Middle School
191 North Country Rd
Miller Place, NY 11764
Health Office 631-474-7258
Fax: 631-474-0362

Laddie A Decker
Sound Beach School
197 North Country Rd
Miller Place, NY 11764
Health office 631-474-2721
Fax: 631-331-4342

Andrew Muller Primary
65 Lower Rocky Point Road
Miller Place, NY 11764
Health Office 631-474-2717
Fax: 631-474-4738

Date of Exam _____

Name: _____ **DOB**_____**GR** _____ **School** _____

IMMUNIZATIONS

☐ Immunization record attached

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma**: ☐Intermittent ☐Persistent

☐**Diabetes**: ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension

☐**Seizures** Type: _____ Last Occurrence:_____

☐**Allergies**: ☐Non-Life-Threatening ☐Life-Threatening: ☐Food ☐Insect ☐Latex ☐Medication

☐Seasonal/Environmental ☐Other: _____Allergen(s): _____

Treatment prescribed: ☐None ☐Antihistamine ☐Epinephrine Auto injector

Significant Medical/Surgical Information: _____

Hx of Concussion/Date:_____

PHYSICAL EXAMINATION

Height: **Weight:** **BMI:** **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:

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

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

Restrictions/Adaptations: _____

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 auto injector, 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.** (form is located on health office website)

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: _____ Date _____

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: _____

NOTE: MUST HAVE PHYSICIAN'S STAMP TO BE VALID