



TUXEDO UNION FREE SCHOOL DISTRICT

Timothy H. Bohlke
SUPERINTENDENT OF SCHOOLS

Gladys Baxter
INTERIM BUSINESS ADMINISTRATOR

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: _____ Age: _____ Grade: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Home Phone: _____ Cell Phone: _____	Date: _____

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|---|---|---|
| <input type="checkbox"/> ADHD | GI Conditions (ulcer, reflux, IBS) | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma/trouble breathing | Headaches/migraines | <input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle) |
| <input type="checkbox"/> Autism/Asperger | Heart Conditions High | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Dental Injuries | Blood Pressure Mental | <input type="checkbox"/> Speech Condition |
| <input type="checkbox"/> Diabetes | Health Condition | <input type="checkbox"/> Urinary Condition |
| <input type="checkbox"/> Ear Infections | (depression, eating disorder, anxiety,
OCD, ODD, etc.) | |

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

No Yes: _____

Please list any additional concerns: _____

Parent/Guardian Signature: _____ Date: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY 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, 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"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental
Asthma <input type="checkbox"/> No <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached <input type="checkbox"/>
<input type="checkbox"/> Yes, indicate type Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____

Seizures <input type="checkbox"/> No <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type <input type="checkbox"/> Type: _____ Date of last seizure: _____
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____
Risk Factors for Diabetes or Pre-Diabetes: <i>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.</i>
BMI _____ kg/m2 Percentile (Weight Status Category): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and >

Hyperlipidemia: No Yes **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K		Date		<input type="checkbox"/> Mental Health: _____
				<input type="checkbox"/> Other: _____

<input type="checkbox"/> Test Done	<input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$	
<input type="checkbox"/> System Review and Exam Entirely Normal		
Check Any Assessment Boxes <u>Outside</u> Normal Limits And Note Below Under Abnormalities		
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary
<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech	<input type="checkbox"/> Skin
<input type="checkbox"/> Neurological	<input type="checkbox"/> Social Emotional	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:		Diagnoses/Problems (list) ICD-10 Code

<input type="checkbox"/> Additional Information Attached		

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Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis <small>Required for boys grade 9</small>	Negative	Positive	Referral	
<small>And girls grades 5 & 7</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications

No Contact Sports **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

No Non-Contact Sports **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY
 Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports
 Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

Brace*/Orthotic Colostomy Appliance* Hearing Aids
 Insulin Pump/Insulin Sensor* Medical/Prosthetic Device* Pacemaker/Defibrillator* Protective Equipment Sport Safety Goggles Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

Order Form for Medication(s) Needed at School attached

List medications taken at home:		

IMMUNIZATIONS

Record Attached Reported in NYSIIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.