



**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 the nurses/health office page on the school website at <https://www.tuckahoeschools.org/> . Please share the attached papers at your child's next visit for a health exam with the health care provider (HCP).

**If you have questions, please contact:**

Fiona Higgins RN  
WEC School Nurse  
[Higginsf@tuckahoeschools.org](mailto:Higginsf@tuckahoeschools.org)  
Phone: (914) 337-5376 ext 1282  
Fax (914) 337-2367

Linda Poulos RN  
TMS/THS School Nurse  
[Poulosl@tuckahoeschools.org](mailto:Poulosl@tuckahoeschools.org)  
Phone: (914) 337-5376 ext 1236  
Fax (914) 337-4126



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

Dear Healthcare Provider,

Education Law requires all New York State (NYS) public school students to have a health exam as a new entrant, 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. 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 New York State School Health Examination Form (included in this packet) provides directions 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.

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

Sincerely,

Dr. Amy Goodman  
Superintendent of Schools

## Instructions for Completion of New York State School Health Examination Form

This form is to be completed in its entirety, except fields designated as optional, by the private provider or school medical director. NYSED requires a physical exam for new entrants and students in grades pre-K or K, 1, 3, 5, 7, 9, and 11; annually for inter-scholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-school special education (CPSE). The date of examination must be not more than 12 months prior to the start of the school year and noted on form.

### Health History

Chronic medical conditions should be listed in patient's problem list.

- ICD-10 codes should accompany diagnoses ONLY for patients who have Medicaid and have an Individualized Education Plan (IEP) for special education in school and receive related services (i.e. nursing, social worker/psychologist, PT/OT/ST, or special transportation).
- Asthma, Seizure disorders, life threatening allergies and Diabetes must be included if diagnosed, and each require a separately attached care plan:
  - Diabetes- requires a Diabetes Medical Management Plan (DMMP) specifying the type of diabetes and most recent hemoglobin A1c (include date), See [NYSDOH Diabetes Medical Management Plan](#);
  - Seizure disorders care plans should include date of last known seizure; See [NYSCSH Seizure ECP with Medication Information](#) ;
  - Asthma - Asthma Action Plans should include medication orders along with directives. See [NYSDOH Asthma Action Plan](#); and
  - Allergies - life threatening allergy care plans should specify what the patient is allergic to. See [AAAI Sample Anaphylaxis Emergency Action Plan](#) .
- Consider screening for T2DM if BMI% >85% and child has 2 or more risk factors: Family history of T2DM, Ethnicity, Symptoms of insulin resistance, History of gestational diabetes in the mother, and or pre-diabetes.
- Include hyperlipidemia and hypertension if diagnosed.
- Include mention of unpaired eye, kidney or testicle if relevant.
- Include mental health diagnoses where permitted by patient/family.
- Under allergies, List all allergies including medication, food, insects, latex, and other environmental allergens.
- Attach medication administration forms for medication which will be administered in school
- Past medical history must include any concussions with the dates of when they occurred.
- Height, weight, and BMI must be provided including percentile for each, as well as marking appropriate BMI category.
- Pulse and respiratory rate are to be documented for students with diagnosed respiratory or cardiac conditions.

### Laboratory and Diagnostic Testing

- Tuberculosis screening, if indicated and performed, should specify type of testing (PPD or Interferon-gamma release assay), result, and test date.  
Screening for vision and hearing in grades PreK or K, 1, 3, 5, 7, and 11, and for scoliosis in grades 5 and 7 for girls, grade 9 for boys that is not done or reported on the school form will be performed by the school.
- Vision screening should include the results of distance acuity testing in each eye (pass is 20/30 or better), an assessment of near vision acuity (pass is 20/40 or better). Color vision (pass/fail) is required if student is attending a new school. See [NYSED Vision Screening Guidelines for Schools](#)
- Hearing screening should be performed at 20 db and pass or fail noted for each frequency (500Hz, 1000Hz, 2000Hz, 4000Hz); children ≥11 years of age should be screened for high frequency hearing loss by testing at 6000Hz and 8000Hz. See [NYSED Hearing Screening Guidelines for Schools](#)
- Lead screening- indicate if screening done for students in PreK or K.

### Physical Examination

- A complete physical exam must include the following systems: HEENT, Dental, Neck, Lymph nodes, Lungs, Abdomen, Back/Spine including screening for scoliosis (see above grade levels), Genitourinary, Extremities, Skin, Neurological, Speech/Language, Social-Emotional, and Musculoskeletal.
- Abnormal findings on review of systems and physical exam should be noted
- Tanner Staging (1-5) must be supplied ONLY for any student in Grades 7 or 8 to play sports at a high school level or Grades 9-12 to play middle school level sports.

### Assessment and Recommendations

- State has no restrictions if applicable
- Please note any restrictions on physical activity including participation in physical education, sports, playground and work. Include applicable limitations on contact sports - baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling, non-contact sports- archery, badminton, bowling, cross country, fencing, golf, gymnastics, riflery, skiing, swimming and diving, and track & field, or other specific restrictions.

- List any accommodations required for participation including but not limited to: Brace/Orthotic, Insulin pump/sensor, Protective equipment, Colostomy appliance, Medical/Prosthetic device, Sport safety goggles, Hearing aids, Pacemaker/Defibrillator, etc. Specific approval and associated documentation may be required if use of device will occur during athletic competitions, please check with athletic governing body for more information.
- Chronic medications should be listed- medication strength/concentration, formulation, dose, frequency, and timing should be noted for those medications to be administered during the school day.
- Providers may attach an immunization form or refer to NYSIIS registry if record available and complete.
- Referrals, such as those for abnormalities on vision or hearing screening should be noted.
- Please include any additional information that may be useful to the school that is not otherwise solicited.

**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>	<b>ICD-10 Code*</b>
<input type="checkbox"/> <b>Additional Information Attached</b>			*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision (w/correction if prescribed)</b>	<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> <div style="margin-left: 20px;"> <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 &amp; Field.  <input type="checkbox"/> <b>Other Restrictions:</b> </div>					
<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      Age of First Menses (if applicable) : _____					
<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>					