Health Services
725 Harrison Street
Syracuse, New York 13210
Ph. (315) 435-4145
Fax (315) 435-4859

PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE)

Name: ____ **Date of Birth:** ____

School: ____________________________ **Gender:** ☐ **M** ☐ **F** **Grade:** ___________ **Date of Physical Examination:** _________________

IMMUNIZATIONS/HEALTH HISTORY

☐ Immunization record attached
☐ No immunization given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____________
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____________
Elevated Lead: ☐ Positive ☐ Negative ☐ Not done Date: _____________
Dental Referral: ☐ Positive ☐ Negative ☐ Not done Date: _____________

Significant Medical/Surgical History: ☐ See attached ____

Specify Current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other ____

Allergies: ☐ LIFE THREATENING ☐ Food: ________________ ☐ Insect: ________________ ☐ Other: ________________
☐ Seasonal ☐ Medication: ______________________________ ______________________________

PHYSICAL EXAM

Height: ________________ **Weight:** ______________ **Blood Pressure:** _____________ **Date of Exam:** _____________________

Body Mass Index: _____ _____ . _____				Referral
Weight Status Category (BMI Percentile):	**Vision** – without glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th – 49th ☐ 50th – 84th	**Vision** – with glasses/contact lenses	R	L	
☐ 85th – 94th ☐ 95th – 98th ☐ 99th + higher	Vision – Near Point	R	L	
	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ EXAM ENTIRELY NORMAL **Tanner:** I. 11. 111. 1V. V. **Scoliosis:** ☐ Negative ☐ Positive: _____________
Specify any abnormality ____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications ____
Name: ____ Dosage/Time: ____
Name: ____ Dosage/Time: ____
Duration of Med order*: ☐ school year ☐ other, please specify: ____
Reason for Med order/Diagnosis* ____
I assess this student to be self-directed ☐ Yes ☐ No
Student may self carry and self administer medication ☐ Yes ☐ No
Student may self carry and self administer medication on a field trip ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK QUALIFICATION/CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:** _____ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball
_____ Non-contact: badminton, bowl, golf, swim, table tennis, archery, weight train, crew, dance, track, run, walk, rope jump
☐ **Specify medical accommodations needed for school:** ____ ☐ **None**
☐ **Known or suspected disability:** ____
☐ **Restriction:** ____
☐ **Protective equipment required:** ☐ **Athletic Cup** ☐ **Sport goggles/impact resistant eyewear** ☐ **Other:** ________________

Provider's Signature: ____ NYS License #*__________________________
Provider's Name/Address: ____ Phone: ______________Fax: _______________
*Required *This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.*

Syracuse City
SCSD
School District

SYRACUSE CITY SCHOOL DISTRICT

Health Services
725 Harrison St.• Syracuse, NY 13210
Phone 315•435•4145• Fax 315•435•4859

Sharon L. Contreras
Superintendent of Schools

Dear Parents/Guardians of ____:

We look forward to welcoming your child to a new school year. We are writing to remind you that New York State requires that each student have a physical examination upon entering school at Pre-K or K, if they are new to the school, and are in grades 2, 4, 7, and 10. If they play sports or need working papers, they must also have a physical. Your own family doctor should do the exam. They know your child well and can measure any changes in your child's health. If needed, they can do referrals for glasses, dentist, etc., at the same time. Enclosed is a blank form that you can ask your doctor to fill out. Please bring it to the nurse's office when you bring your child to school or you can mail it to: **School Nurse**

____

(School Name & Address)

We understand that some children may not receive their yearly medical exam until after school starts. You can send it in when it is completed. Please call your doctor now to set up an appointment.

Please sign and return this form to the school health office by __________________.
(Date)

I will provide a physical exam by my own provider. Appointment is scheduled on ____________.
(Date)

For further information, please contact your school nurse, 416-1956 or the Health Services Office at 435-4145.

___________________________ ___________________________________

Student's Name **Signature of Parent/Guardian**

___________________________ ___________________________________

School **Date**