ANNUAL HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: EVCS requests a copy of your child's physical each school year

Name: ______________________ DOB: ______________ Gender: ☐M ☐F

School: Elmwood Village Charter School Grade: ☐No Grade **Exam Date**: ______________

IMMUNIZATIONS

☐ Immunization record attached ☐ Immunizations reported on NYSIIS ☐ No immunizations received today	☐Immunizations received today: ☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma**: ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes**: ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures** Type: ______________ Last Occurrence: ________ ☐Emergency Care Plan Attached

☐**Allergies**: ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

☐Hx of Anaphylaxis: Last occurrence: ________ Previous symptoms: ______________

Treatment prescribed: ☐None ☐Antihistamine ☐Epinephrine Auto injector

Significant Medical/Surgical Information:	**Diagnostic Tests**	**Positive**	**Negative**	**Not Done**	**Date**
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

Height: **Weight**: **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 Athletics.

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

- ☐ **No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
- ☐ **Other Specific Restrictions**:

Accommodations / Protective Equipment:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	
	☐Brace/Orthotic	☐Medical /Prosthetic Device	
	☐Hearing Aides	☐Other:	

MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Diagnosis ______________________________

1) Medication ______________________________

Dose ______________ Route ______________ Time(s) ______________

2) Medication ______________________________

Dose ______________ Route ______________ Time(s) ______________

3) Medication ______________________________

Dose ______________ Route ______________ Time(s) ______________

Check the Student's Medication Delivery Status

☐ Nurse Dependent ☐ Supervised Student ☐ Independent Student

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: ______________________________

HEALTH CARE PROVIDER PERMISSION FOR INDEPENDENT USE

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

This student is diagnosed with: ______________________________

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ ______________________ which requires rapid administration of ______________

(State the Diagnosis) (Medication Name)

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: ______________

Provider Name: (please print) ______________________ Phone #: ( )

Provider Address: ______________________ Fax #: ( )