



ELMWOOD VILLAGE
CHARTER SCHOOL

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 NYSIS
 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

PHYSICAL EXAMINATION

Height:	Weight:	BP:	Pulse:	Respirations:				
Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive				Vision		Right	Left	Referral
Degree of deviation:				Distance acuity				<input type="checkbox"/> Yes <input type="checkbox"/> No
Angle of trunk rotation via scoliometer:				Distance acuity with lenses				<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Status Category (BMI Percentile): _____				Vision - near vision				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <5 th <input type="checkbox"/> 85 th - 94 th				Vision - color perception		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 5 th - 49 th <input type="checkbox"/> 95 th - 98 th				Hearing		Right	Left	Referral
<input type="checkbox"/> 50 th - 84 th <input type="checkbox"/> 99 th & higher				<input type="checkbox"/> 20 db sweep screen both ears or				<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Athletic Cup	<input type="checkbox"/> Insulin Pump/Insulin Sensor	
	<input type="checkbox"/> Brace/Orthotic	<input type="checkbox"/> Medical /Prosthetic Device	
	<input type="checkbox"/> Hearing Aides	<input type="checkbox"/> 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 #: ()