REQUIRED NYS HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
Note: Portledge School requires a physical exam for new entrants and students annually.
355 Duck Pond Rd., Locust Valley, NY 11560 • (516) 750-3100 • Fax: (516) 674-7063 • www.portledge.org

**STUDENT INFORMATION**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex:</th>
<th>M ☐ F ☐</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
<td></td>
</tr>
</tbody>
</table>

**HEALTH HISTORY**

- **ALLERGIES**: No ☐ Yes, indicate type ☐
- **MEDICATION/TREATMENT ORDER ATTACHED**: Food ☐ Insects ☐ Latex ☐
- **MEDICATION/TREATMENT ORDER ATTACHED**: Medication ☐ Environmental ☐
- **ANAPHYLAXIS CARE PLAN ATTACHED**: Yes ☐ No ☐
- **ASTHMA**: No ☐ Yes, indicate type ☐
- **INTERMITTENT/PERSISTENT**: Intermittent ☐ Persistent ☐ Other: __________
- **ASTHMA CARE PLAN ATTACHED**: Yes ☐ No ☐
- **SEIZURES**: No ☐ Yes, indicate type ☐
- **SEIZURE CARE PLAN ATTACHED**: Yes ☐ No ☐
- **DATE OF LAST SEIZURE**: __________
- **DIABETES**: No ☐ Yes, indicate type ☐
- **TYPE 1/TYPE 2**: Type 1 ☐ Type 2 ☐
- **DIABETES MEDICAL MGMT. PLAN ATTACHED**: Yes ☐ No ☐
- **HbA1c RESULTS**: __________
- **DATE DRAWN**: __________

**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” ☐ 5”-49” ☐ 50”-84” ☐ 85”-94” ☐ 95”-98” ☐ 99” and>

**HYPERLIPIDEMIA**: No ☐ Yes ☐

**HYPERTENSION**: No ☐ Yes ☐

**PHYSICAL EXAMINATION/ASSESSMENT**

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Respiration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TESTS</td>
<td>Positive</td>
<td>Negative</td>
<td>Date</td>
<td>Other Pertinent Medical Concerns</td>
</tr>
<tr>
<td>PPD/PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>One Functioning: ☐ Eye ☐ Kidney ☐ Testicle</td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>Concussion – Last Occurrence: __________</td>
</tr>
<tr>
<td>LEAD LEVEL REQUIRED GRADES PRE-K &amp; K</td>
<td>☐</td>
<td></td>
<td></td>
<td>Date: __________</td>
</tr>
</tbody>
</table>

- ☐ Test Done ☐ Lead Elevated > 10 µg/dL

**SYSTEM REVIEW AND EXAM ENTIRELY NORMAL**

**CHECK ANY ASSESSMENT BOXES OUTSIDE NORMAL LIMITS AND NOTE BELOW UNDER ABNORMALITIES**

- ☐ Heent ☐ Dental ☐ Neck ☐ Lymph Nodes ☐ Cardiovascular ☐ Abdomen ☐ Back/Spine ☐ Genitourinary ☐ Extremities ☐ Skin ☐ Neurological ☐ Speech ☐ Social Emotional ☐ Musculoskeletal

- ☐ Assessment/Abnormalities Noted/Recommendations: __________

- ☐ Diagnoses/Problems (list) | ICD-10 Code |
- ☐ Additional Information Attached
**SCREENINGS**

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
<td>20/</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Vision – Color</td>
<td></td>
<td></td>
<td>□ Pass</td>
<td>□ Fail</td>
</tr>
</tbody>
</table>

**Hearing**

<table>
<thead>
<tr>
<th>Right dB</th>
<th>Left dB</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Yes</td>
</tr>
</tbody>
</table>

**Scoliosis**

<table>
<thead>
<tr>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□ Yes</td>
</tr>
</tbody>
</table>

**Deviation Degree:**

**Trunk Rotation Angle:**

---

**Recommendations:**

**Use the Interscholastic Sports Categories (below) for restrictions or modifications**

- **Full Activity** without restrictions including Physical Education and Athletics.
- **Restrictions/Adaptations**
  - □ No Contact Sports
  - □ No Limited Contact Sports
  - □ No Non-Contact Sports
  - □ 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.

**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 (please print): ____________________________
- Provider Address: _____________________________________
- Phone: ____________________________
- Fax: ____________________________