ST. FRANCIS PREPARATORY SCHOOL MEDICAL OFFICE
HEALTH EXAMINATION FORM

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STUDENT NAME:_____ COR: _____ SEX: ❑ M ❑ F

SCHOOL NAME:_____ DOB: _____

Grade (check): ❑7 ❑8 ❑9 ❑10 ❑11 ❑12 EXAM DATE:

HEALTH HISTORY

ALLERGIES ❑ NO ❑ YES, INDICATE TYPE	TYPE: ❑ MEDICATION/TREATMENT ORDER ATTACHED ❑ ANAPHYLAXIS CARE PLAN ATTACHED
ASTHMA ❑ NO ❑ YES, INDICATE TYPE	❑ INTERMITTENT ❑ PERSISTENT ❑ OTHER: ❑ MEDICATION/TREATMENT ORDER ATTACHED ❑ ASTHMA CARE PLAN ATTACHED
SEIZURES ❑ NO ❑ YES, INDICATE TYPE:	TYPE: DATE OF LAST SEIZURE: ❑ MEDICATION/TREATMENT ORDER ATTACHED ❑ SEIZURE CARE PLAN ATTACHED
DIABETES ❑ NO ❑ YES, INDICATE TYPE:	TYPE: ❑ 1 ❑ 2 ❑ MEDICATION/TREATMENT ORDER ATTACHED ❑ 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): ❑ <5th ❑ 5th-49th ❑ 50th-84th ❑ 85th-94th ❑ 95th-98th ❑ 99th and>

HYPERLIPIDEMIA: ❑ NO ❑ YES ❑ NOT DONE HYPERTENSION: ❑ NO ❑ YES ❑ NOT DONE

PHYSICAL EXAMINATION/ASSESSMENT

HEIGHT: WEIGHT: BOP: PULSE: RESPIRATIONS:

LABORATORY TESTING	POSITIVE	NEGATIVE	DATE	LIST OTHER PERTINENT MEDICAL CONCERNS (e.g. CONCUSSION, / MENTAL HEALTH, ONE FUNCTIONING ORGAN)
TB-PRN	❑	❑		History of COVID Virus: ❑
SICKLE CELL SCREEN-PRN	❑	❑		
LEAD LEVEL REQUIRED GRADES PRE-K & K			DATE	
❑ TEST DONE ❑ LEAD ELEVATED ≥5 µg/dL				

❑ SYSTEM REVIEW AND ABNORMAL FINDINGS LISTED BELOW

❑ HEENT	❑ LYMPH NODES	❑ ABDOMEN	❑ EXTREMITIES	❑ SPEECH
❑ DENTAL	❑ LUNGS	❑ BACK/SPINE	❑ SKIN	❑ SOCIAL EMOTIONAL
❑ NECK	❑ CARDIOVASCULAR	❑ GENITOURINARY	❑ NEUROLOGICAL	❑ MUSCULOSKELETAL

❑ ASSESSMENT/ABNORMALITIES NOTED/RECOMMENDATIONS:	DIAGNOSIS/PROBLEMS (LIST) ICD-10 CODE*
❑ ADDITIONAL INFORMATION ATTACHED	*REQUIRED ONLY FOR STUDENTS WITH AN IEP RECEIVING Medicaid

STUDENT NAME:_____ COR: _____ DOB: _____

SCREENINGS

VISION (w/ correction if prescribed)	RIGHT	LEFT	REFERRAL	NOT DONE
DISTANCE ACUITY	20/	20/	❑ NO ❑ YES	❑
NEAR VISION ACUITY	20/	20/		❑
COLOR PERCEPTION SCREENING	❑ PASS ❑ FAIL			❑
NOTES:				

HEARING *PASSING INDICATES STUDENT CAN HEAR 20DB AT ALL FREQUENCIES: 500, 1000, 2000, 3000, 4000HZ - FOR GRADES 7 & 11 ALSO TEST AT 6000 & 8000 HZ				NOT DONE
PURE TONE SCREENING	RIGHT ❑ PASS ❑ FAIL	LEFT ❑ PASS ❑ FAIL	REFERRAL ❑ PASS ❑ FAIL	❑
NOTES:				

SCOLIOSIS Screen Boys in grade 9, and Girls in grades 5 & 7	NEGATIVE	POSITIVE	REFERRAL	NOT DONE
	❑	❑	❑ YES ❑ NO	❑

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

❑ STUDENT MAY PARTICIPATE IN ALL ACTIVITIES WITHOUT RESTRICTIONS.

❑ STUDENT IS RESTRICTED FROM PARTICIPATION IN:

- ❑ CONTACT SPORTS: BASKETBALL, COMPETITIVE CHEERLEADING, DIVING, DOWNHILL SKIING, LACROSSE, FOOTBALL, GYMNASTICS, ICE HOCKEY, FIELD HOCKEY, SOCCER, WRESTLING
- ❑ LIMITED CONTACT: BASEBALL, FENCING, SOFTBALL, VOLLEYBALL
- ❑ NON-CONTACT: ARCHERY, BADMINTON, BOWLING, CROSS-COUNTRY, GOLF, RIFLERY, SWIMMING, TENNIS, TRACK & FIELD
- ❑ OTHER RESTRICTIONS:

DEVELOPMENTAL STAGE FOR ATHLETIC PLACEMENT PROCESS ONLY REQUIRED FOR STUDENTS IN GRADES 7 & 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.

TANNER STAGE: ❑ I ❑ II ❑ III ❑ IV ❑ V AGE OF FIRST MENSUS (if applicable):

❑ **OTHER ACCOMMODATIONS*:** (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.

MEDICATIONS

❑ ORDER FORM FOR MEDICATION(S) NEEDED AT SCHOOL ATTACHED

IMMUNIZATIONS

❑ RECORD ATTACHED ❑ REPORTED IN NYSIIS

HEALTH CARE PROVIDER

MEDICAL PROVIDER SIGNATURE:

PROVIDER NAME: *(PLEASE PRINT)*

PROVIDER ADDRESS:

PHONE: **FAX:**