LONG ISLAND SCHOOL FOR THE GIFTED

165 Pidgeon Hill Road
South Huntington, NY 11746
(631) 423-3557
www.lisg.org
Carol Yilmaz, Founder
Patricia Geyer, Ed.D., Head of School

June 2019

Dear Parent or Guardian:

New York Education Law requires that a physical examination be done for all students entering grades K, 1, 3, 5, 7, 9 and all transfer students.

Enclosed is the physical examination form to be completed by your child's health care provider and returned to the school nurse. This physical examination form must be submitted to the school nurse **no later than October 7, 2019**.

Camp forms do not include the information required for school.

I have also enclosed an Annual Dental Form and a Health History Form. Please take a moment to fill out the Health History Form as accurately as possible. Most importantly, include a complete list of **food** and **medication allergies** as well as any special needs your child may have.

ALL STUDENTS MUST HAVE UP-TO-DATE IMMUNIZATIONS AS REQUIRED BY THE NEW YORK STATE PUBLIC HEALTH LAW.

Thank you for your cooperation.

Sincerely,

Karen Jacobsen, RN
Kjacobsen@lisg.org

KJ/jmo
Enclosures

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HEALTH HISTORY FORM

Child's Name _____ Sex: _____

Date of Birth _____ Place of Birth _____

Address _____

Telephone _____

Father's Name _____ Work Phone _____

Mother's Name _____ Work Phone _____

Medical Provider Name: _____ Telephone _____

Birth/Delivery History _____

_____

Please check Yes or No for each of the following:

	Yes	No		Yes	No		Yes	No
Allergies	[ ]	[ ]	Diabetes	[ ]	[ ]	Kidney Problems	[ ]	[ ]
Anemia	[ ]	[ ]	Ear Infections	[ ]	[ ]	Pneumonia	[ ]	[ ]
Arthritis	[ ]	[ ]	Eye Problems	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]
Asthma	[ ]	[ ]	Fifth Disease	[ ]	[ ]	Scarlet Fever	[ ]	[ ]
Chicken Pox	[ ]	[ ]	Hearing Problems	[ ]	[ ]	Seizures	[ ]	[ ]
Congenital Defects	[ ]	[ ]	Heart Condition	[ ]	[ ]	Surgery	[ ]	[ ]
						Tuberculosis	[ ]	[ ]

If you checked Yes to any of the above, give details:

_____

_____

_____

Does your child receive any medication on a regular basis? NO____ YES____

If you answered Yes, give details: _____

_____

_____

_____ _____

Signature of Parent/Guardian Date

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REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ 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):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

OVER

Name:			DOB:	
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

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

Explain: _____

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)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

DENTAL FORM

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Dear Parent:

Our school has a health program that is designed to improve, protect, and promote the health of the child. As part of this health program, we strongly urge all parents to have their children visit their dentist at least once a year for a dental examination and whatever treatment may be necessary. In the interest of better dental health, please have your child take this form to a dentist of your choice and return it to the school nurse.

Yours truly,
Karen Jacobsen RN
School Nurse

REPORT OF DENTAL EXAMINATION

This is to certify that I have examined the teeth of:

Name _____
(Last Name) (First) (Grade)

_____
(School) (Home Room Teacher)

Please check one of the following statements:

___ All necessary dental treatment has been completed at this time.

___ Treatment is in progress.

___ No dental treatment is necessary at this time.

Further Recommendations:

_____

_____

_____

_____

Dentist: _____ Date: _____
(Print and Sign Name)

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE'S OFFICE