

RAMBAM MESIVTA - REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM - 2023 - 2024
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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: Yes Not Done **Hypertension:** Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:		Affirmed Name (if applicable):			DOB:	
SCREENINGS						
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11						
Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done	
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>	
Near Vision Acuity		20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>	
Notes						
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done	
Pure Tone Screening		Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes	<input type="checkbox"/>	
Notes						
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK						
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act						
<input type="checkbox"/> Student may participate in all activities without restrictions.						
If Restrictions Apply – Complete the information below						
<input type="checkbox"/> Student is restricted from participation in:						
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.						
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.						
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.						
<input type="checkbox"/> Other Restrictions:						
Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V						
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.						
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.						
MEDICATIONS						
<input type="checkbox"/> Order Form for medication(s) needed at school attached						
COMMUNICABLE DISEASE				IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam				<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER						
Healthcare Provider Signature:						
Provider Name: <i>(please print)</i>						
Provider Address:						
Phone:				Fax:		
Please Return This Form to Your Child's School Health Office When Completed.						

Health Office - Rambam Mesivta

Vaccine Administration Record for Children & Teens

2023- 2024

Patient name _____

Birthdate _____ Chart number _____

PRACTICE NAME AND ADDRESS

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to the child's parent or legal representative and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine ¹	Date vaccine given (mo/day/yr)	Funding Source (F,S,P) ²	Site ³	Vaccine		Vaccine Information Statement (VIS)		Vaccinator ⁵ (signature or initials and title)
					Lot #	Mfr.	Date on VIS ⁴	Date given ⁴	
Hepatitis B⁶ (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM. ⁷									
Diphtheria, Tetanus, Pertussis⁶ (e.g., DTaP, DTaP/Hib, DTaP-HepB-IPV, DT, DTaP-IPV/Hib, DTaP-IPV, Tdap, Td) Give IM. ⁷									
Haemophilus influenzae type b⁶ (e.g., Hib, Hib-HepB, DTaP-IPV/Hib, DTaP/Hib, Hib-MenCY) Give IM. ⁷									
Polio⁶ (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV) Give IPV Subcut or IM. ⁷ Give all others IM. ⁷									
Pneumococcal (e.g., PCV7, PCV13, conjugate; PPSV23, polysaccharide) Give PCV IM. ⁷ Give PPSV Subcut or IM. ⁷									
Rotavirus (RV1, RV5) Give orally (po).									

▶ See page 2 to record measles-mumps-rubella, varicella, hepatitis A, meningococcal, HPV, influenza, and other vaccines (e.g., travel vaccines).

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the site where vaccine was administered as either RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or NAS (intranasal).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.
7. IM is the abbreviation for intramuscular; Subcut is the abbreviation for subcutaneous.

Abbreviation	Trade Name and Manufacturer
DTaP	Daptacel (Sanofi Pasteur); Infanrix (GlaxoSmithKline [GSK]); Tripedia (Sanofi Pasteur)
DT (pediatric)	Generic (Sanofi Pasteur)
DTaP-HepB-IPV	Pediarix (GSK)
DTaP-IPV/Hib	Pentacel (Sanofi Pasteur)
DTaP-IPV	Kinrix (GSK); Quadracel (Sanofi Pasteur)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK); can be given to teens age 18 and older
Hib	ActHIB (Sanofi Pasteur); Hiberix (GSK); PedvaxHIB (Merck)
Hib-MenCY	MenHibrix (GSK)
IPV	Ipol (Sanofi Pasteur)
PCV13	Prenar 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
RV1	Rotarix (GSK)
RV5	RotaTeq (Merck)
Tdap	Adacel (Sanofi Pasteur); Boostrix (GSK)
Td	Decavac, Tenivac (Sanofi Pasteur); Generic (MA Biological Labs)

Health Office - Rambam Mesivta

Vaccine Administration Record for Children & Teens (Continued)

Patient name _____

Birthdate _____ Chart number _____

PRACTICE NAME AND ADDRESS

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to the child's parent or legal representative and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine ¹	Date vaccine given (mo/day/yr)	Funding Source (F,S,P) ²	Site ³	Vaccine		Vaccine Information Statement (VIS)		Vaccinator ⁵ (signature or initials and title)
					Lot #	Mfr.	Date on VIS ⁴	Date given ⁴	
Measles, Mumps, Rubella⁶ (e.g., MMR, MMRV) Give Subcut. ⁷									
Varicella⁶ (e.g., VAR, MMRV) Give Subcut. ⁷									
Hepatitis A (HepA) Give IM. ⁷									
Meningococcal ACWY; CY (e.g., MenACWY [MCV4]; Hib-MenCY) Give MenACWY and Hib-MenCY IM. ⁷									
Meningococcal B (e.g., MenB) Give MenB IM. ⁷									
Human papillomavirus (e.g., HPV2, HPV4, HPV9) Give IM. ⁷									
Influenza (e.g., IIV3, IIV4, ccIIV3, RIV3, LAIV4) Give IIV3, IIV4, ccIIV3, and RIV3 IM. ⁷ Give LAIV4 NAS. ⁷									
Other									

► See page 1 to record hepatitis B, diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b, polio, pneumococcal, and rotavirus vaccines.

How to Complete this Record

- Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
- Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
- Record the site where vaccine was administered as either RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or NAS (intranasal).
- Record the publication date of each VIS as well as the date the VIS is given to the patient.
- To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
- For combination vaccines, fill in a row for each antigen in the combination.
- IM is the abbreviation for intramuscular; Subcut is the abbreviation for subcutaneous.

Abbreviation	Trade Name and Manufacturer
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MMRV	ProQuad (Merck)
HepA	Havrix (GlaxoSmithKline [GSK]); Vaqta (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4, HPV9	Gardasil, Gardasil 9 (Merck)
LAIV4 (live attenuated influenza vaccine, quadrivalent)	FluMist (MedImmune)
IIV3 (inactivated influenza vaccine, trivalent), IIV4 (inactivated influenza vaccine, quadrivalent), ccIIV3 (cell culture-based inactivated influenza vaccine, trivalent), RIV3 (inactivated recombinant influenza vaccine, trivalent)	Fluarix (GSK); Flublok (Protein Sciences Corp.); Afluria, Flud, Flucelvax, Fluvirin (Seqirus); FluLaval (GSK); Fluzone (Sanofi Pasteur)
MenACWY	Menactra (Sanofi Pasteur); Menveo (GSK)
HibMenCY	MenHibrix (GSK)
MenB	Bexsero (GSK); Trumenba (Pfizer)