

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

1. Student Name: _____

2. Date of Birth: _____

3. Sex: _____

4. Address: _____

5. City: _____ State: _____ Zip: _____

6. School Name: _____

7. School Address: _____

8. School City: _____ State: _____ Zip: _____

9. Parent/Guardian Name: _____

10. Parent/Guardian Address: _____

11. Parent/Guardian City: _____ State: _____ Zip: _____

12. Parent/Guardian Phone: _____

13. Student's Health History (Last 12 Months):

Illness	Frequency
Cold/Flu	_____
Allergies	_____
Asthma	_____
Stomach Issues	_____
Headaches	_____
Other	_____

14. Current Medications:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Immunization History (Last 12 Months):

Vaccine	Date	Provider
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Physical Examination Results:

System	Findings
General	_____
Cardiovascular	_____
Respiratory	_____
Gastrointestinal	_____
Genitourinary	_____
Neurological	_____
Musculoskeletal	_____
Skin	_____
Other	_____

17. Student's Signature: _____

18. Parent/Guardian Signature: _____

19. Health Care Provider Signature: _____

20. Health Care Provider Title: _____

21. Health Care Provider Address: _____

22. Health Care Provider City: _____ State: _____ Zip: _____

23. Health Care Provider Phone: _____

Additional Information Attached

Name:

DOB:

SCREENING

Pure Tone Screening

Submit

Referral

☐ Yes ☐ No

Additional Comments

Urgent Referral

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