

# ISLIP PUBLIC SCHOOLS

**WING ELEMENTARY SCHOOL** ♦ 1WINGANHAUPPAUGE RD. ♦ PHONE (631) 650-8475 ♦ FAX (631) 650-8458  
**COMMACK RD. ELEMENTARY SCHOOL** ♦ 300 COMMACK RD. ♦ PHONE (631)-650-8625 ♦ FAX (631) 650-8608  
**SHERWOOD ELEMENTARY SCHOOL** ♦ 301 SMITH AVE. ♦ PHONE (631) 650-8675 ♦ FAX (631) 650-8658  
**ISLIP MIDDLE SCHOOL** ♦ 211 MAIN ST. ♦ PHONE (631) 650-8525 ♦ FAX (631) 650-8508  
**ISLIP HIGH SCHOOL** ♦ 2508 UNION BLVD. ♦ PHONE (631) 650-8325 ♦ FAX (631) 650-8308

***NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).***

## ANNUAL HEALTH EXAMINATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS/HEALTH HISTORY

<input type="checkbox"/> Immunization record attached	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done	Date: _____
<input type="checkbox"/> No immunizations given today	PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done	Date: _____
<input type="checkbox"/> Immunizations given since last Health Appraisal:	Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	Date: _____
	Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	Date: _____

Varicella disease date \_\_\_\_\_ Varicella titer \_\_\_\_\_ Varicella Vaccine (1) \_\_\_\_\_ (2) \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Specify current diseases:  Asthma Diabetes:  Type 1  Type 2  Hyperlipidemia  Hypertension

Other: \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_

Seasonal  Medication: \_\_\_\_\_

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Urine: Sugar \_\_\_\_\_ Protein \_\_\_\_\_ Pulse: \_\_\_\_\_ Scoliosis: \_\_\_\_\_ Hernia: \_\_\_\_\_

Body Mass Index: _____ - _____				<i>Referral</i>
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Vision – without glasses/contact lenses	R	L	
	Vision – with glasses/contact lenses	R	L	
	Vision – Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

Protective eyewear for athletics: (CHECK TYPE) (1) Rx Goggles  (2) Non-Rx Goggles  (3) Contact Lenses   
 (4) Polycarbonate Lenses in Glasses  (5) None Required

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V.

Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

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**PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION**

**Free from contagions & physically qualified for all physical education, sports, playground work & school activities OR only as checked:**

\_\_\_\_\_ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

\_\_\_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: \_\_\_\_\_  None

Known or suspected disability: \_\_\_\_\_  Please monitor

\_\_\_\_\_  Please monitor

Restrictions: \_\_\_\_\_

Protective equipment required:     Athletic Cup     Sport goggles/impact resistant eyewear     Other \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days**

(PHYSICIAN'S STAMP)

4-18-08