REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

[redacted]

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SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	With Correction • Yes • No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	Yes	
Near Vision Acuity		20/	20/	Yes	
Color Perception Screening	Pass Fail				

Notes

Hearing Screening Passing indicates student can hear

Sachem Central School District

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: …M …F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

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Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	…	…	
Seen a medical specialist	…	…	
Had allergies:	…	…	..food ..environmental ..insect ..medication ..other

Name:	Affirmed Name (if applicable)	DOB:

If you answered YES to any questions give details. Sign and date below.	

Is there any condition that would prevent your child from participating in physical education?
…No … Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

Parent/Guardian Signature: _____ Date: _____