



# Bard Academy



# SIMON'S ROCK at Bard College

## PHYSICAL EXAM RECORD

Simon's Rock requires from your medical provider a record of a physical exam **within the last 12 months**. Please have your history reviewed by your health care provider and have them fill out the information below. **State regulation mandates that Health Services be in possession of relevant health records before a student assumes residency at the College. Include copies of any other records you feel pertinent.**

\_\_\_\_\_  
Last Name First Name Middle

\_\_\_\_\_  
Date of Birth Date of Examination

\_\_\_\_\_  
Height Weight

\_\_\_\_\_  
Blood Pressure Pulse

\_\_\_\_\_  
Medication Allergies

\_\_\_\_\_  
ACTIVE medical/psychiatric issues:

\_\_\_\_\_

\_\_\_\_\_  
Significant PAST medical/psychiatric issues:

\_\_\_\_\_

\_\_\_\_\_  
Current Medications:

\_\_\_\_\_

\_\_\_\_\_

This individual has been prescribed an EpiPen:  YES  NO

*If yes, EpiPen form must be completed and returned*

Please check if normal and explain otherwise.

<input type="checkbox"/>	HEENT	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	Spine (Scoliosis)
<input type="checkbox"/>	Neck	<input type="checkbox"/>	Skin	<input type="checkbox"/>	Neuro
<input type="checkbox"/>	Cardiac	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	Abdomen
				<input type="checkbox"/>	GU

Healthcare Provider Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

(must be non-family member)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
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/m<sup>2</sup>

**Percentile (Weight Status Category):**  < 5<sup>th</sup>  5<sup>th</sup>- 49<sup>th</sup>  50<sup>th</sup>- 84<sup>th</sup>  85<sup>th</sup>- 94<sup>th</sup>  95<sup>th</sup>- 98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  Yes  Not Done      **Hypertension:**  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$
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:	
<b>SCREENINGS</b>						
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11						
<b>Vision</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
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						
<b>Hearing</b> 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.					<b>Not Done</b>	
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>	
Notes						
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK</b>						
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominic Murray Sudden Cardiac Arrest Prevention Act						
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>						
<b>If Restrictions Apply</b> – Complete the information below						
<input type="checkbox"/> <b>Student is restricted from participation in:</b>						
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.						
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.						
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.						
<input type="checkbox"/> <b>Other Restrictions:</b>						
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.						
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V						
<input type="checkbox"/> <b>Other Accommodations*:</b> (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.						
<b>MEDICATIONS</b>						
<input type="checkbox"/> Order Form for medication(s) needed at school attached						
<b>COMMUNICABLE DISEASE</b>				<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam				<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>						
Healthcare Provider Signature:						
Provider Name: <i>(please print)</i>						
Provider Address:						
Phone:				Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>						