

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**SCREENINGS**

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	*
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		

**Recommendations:**

**RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK**

- Full Activity** without restrictions including Physical Education and Athletics.
  - Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications
    - No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
    - No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
    - Other Restrictions:**
  - Developmental Stage for Athletic Placement Process ONLY**  
 Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports  
 Student is at **Tanner Stage:**  I  II  III  IV  V
  - Accommodations:** Use additional space below to explain
 

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:
- \*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: \_\_\_\_\_

**MEDICATIONS**

**Order Form for Medication(s) Needed at School attached**

List medications taken at home: \_\_\_\_\_

**IMMUNIZATIONS**

Record Attached  Reported in NYSIS Received Today:  Yes  No

**HEALTH CARE PROVIDER**

Medical Provider Signature: \_\_\_\_\_  
 Provider Name: *(please print)* \_\_\_\_\_  
 Provider Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

Date: \_\_\_\_\_

Stamp: \_\_\_\_\_

**Please Return This Form To Your Child's School When Entirely Completed.**