THE NEW YORK CITY DEPARTMENT OF EDUCATION
JOEL I. KLEIN, *Chancellor*
SCHOOL PROGRAMS & SUPPORT SERVICES
52 Chambers Street, Room 220 · New York, NY 10007

REQUEST FOR PHYSICAL EXAMINATION

Dear Parent Guardian: Date Letter Sent: _____

As part of the evaluation process for special education services, the New York State Education Department approved evaluation site you select must provide or review a current physical examination. Please have your doctor/clinic complete and return the form to:
Name:_____ Title: _____ Telephone: _____

Evaluation Site: _____

Address: _____
If you need help in obtaining a physical examination, staff from the evaluation site will assist you. Please note that your signed consent for release of these records is attached.

Name of the Child: Last: _____ First: _____

School: _____ Date of Birth: _____

CSE Case #:_____ NYC Student ID#: _____

THIS SECTION TO BE COMPLETED BY DOCTOR/HEALTH CARE PROVIDER/CLINIC
Has the student had or now have any of the following:

☐ ADHD	☐ Asthma	☐ Autism	☐ Allergies List _____
☐ Blood Disorders	☐ Cancer	☐ Diabetes	☐ Congenital Hearth Disease
☐ Hearing Problem	☐ Neurological Disorder	☐ Orthopedic Problem	☐ Seizures (Type) _____
☐ Shunt	☐ Speech Problem	☐ Tuberculosis	☐ Vision Problem

☐ Other: _____
If you have checked off any of the above boxes, please give a brief history
_____
_____
_____

	Reason	Date	Place
☐ Hospitalizations	_____	_____	_____
☐ Surgery (what kind)	_____	_____	_____
☐ Serious illnesses	_____	_____	_____
☐ Serious Accidents	_____	_____	_____
☐ Other Problems or Limitations	_____	_____	_____

If you have checked any of the above boxes, please give a brief history
_____
_____
_____

PHYSICAL EXAMINATION Height: _____ (____%) Weight: _____ Blood Pressure: _____
GENERAL APPEARANCE (NUTRITIONAL STATUS/SPECIAL DIET): _____
_____

NL	AB	NL	AB	NL	AB	NL	AB
☐	☐ Heent	☐	☐ Lungs	☐	☐ Extremities	☐	☐ Language
☐	☐ Dental status	☐	☐ Cardiovascular	☐	☐ Back	☐	☐ Gross Motor
☐	☐ Neck	☐	☐ Abdomen	☐	☐ Skin	☐	☐ Fine Motor
☐	☐ Lymph	☐	☐ Genito Urinary	☐	☐ Neuro		

DESCRIBE ABNORMALITIES:
_____
_____

REQUEST FOR PHYSICAL EXAMINATION

Name of Child: Last: _____ First: _____

SCREENING TESTS:	DATE	RESULTS		DATE	RESULTS	VISION	DATE	RESULTS
Hematoctit/Hemoglobin	_____	_____	Urinalysis	_____	_____	Far	_____	_____
HGB Electrophoresis	_____	_____	Audio Sweep	_____	_____	Near	_____	_____
Scoliosis	_____	_____	Threshold	_____	_____	Fusion	_____	_____
Sickle Cell Anemia	_____	_____	Medical cleared for FM Unit		YES☐ NO☐	Color	_____	_____

LEAD:

FED _____ (Date) _____ (Results) ZNP _____ (Date) _____ (Results) More Lead _____ (Date) _____ (Results) Venous Lead _____ (Date) _____ (Results)

TB: MANTOUX	DATE	RESULTS		DATE	RESULTS
(PPD) Implanted	_____	☐ Negative MM	CHEST X-RAY	_____	_____
READ	_____	☐ Positive MM			
BGG VACCINE	_____	YES☐ ☐ NO	TREATMENT PLAN: _____		
			MEDICATION START DATE: _____		D/C DATE: _____

IMMUNIZATION – DATES

DPT or DT or TD	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	MEASLES	__/__/__	__/__/__
Poho (TOPV) Sabin	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	MUMPS	__/__/__	__/__/__
IPV (Solk)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	RUBELLA	__/__/__	__/__/__
HIB	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	MR	__/__/__	__/__/__
HEP B STATUS	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	MMR	__/__/__	__/__/__

DIAGNOSIS

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATION/TREATMENT TO BE ADMINISTERED IN SCHOOL ONLY:

Name of Medication: _____ Dosage: _____ Route; _____

PRN order? (If so, under what conditions should medication be given?) _____

Indicate any medically provided treatment required in school (e.g. , tracheostomy care, catheterization G-tube feeding etc.)

Indicate specific instructions for providing treatment: _____

Frequency/time to be provided: _____

Conditions under which treatment should be provided: _____

Conditions under which treatment should not be provided: _____

Possible side effects/adverse reactions to treatment: _____

RECOMMENDATIONS:

☐ Regular Physical Education ☐ No Physical Education

☐ No Competitive Sports ☐ Restrictions (specify) _____

OT/PT SPEECH THERAPY

(Please complete for OT/PT Speech Therapy if necessary)

I am referring the student for an evaluation for the service(s) and for the provision of: _____ if it is determined to be appropriate as result of such evaluation.

Fill in type of service(s)

Physician Name: (Please print) _____ Date of Exam: _____

Name of Facility: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Physician's Signature: _____ License #: _____