

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires a physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: M F
 School: _____ Grade: No Grade Exam Date: _____

IMMUNIZATIONS

Immunization record attached
 Immunizations reported on NYSIS
 No immunizations received today

Immunizations received today:
 Will return on: _____ to receive: _____

HEALTH HISTORY

Asthma: Intermittent Persistent Asthma Action Plan Attached
 Diabetes: Type I Type 2 Hyperlipidemia Hypertension Diabetes Medical Mgmt Plan Attached
 Seizures Type: _____ Last Occurrence: _____ Emergency Care Plan Attached
 Allergies: Non Life-Threatening Life-Threatening Emergency Care Plan Attached
 Type: Food Insect Latex Medication Seasonal/Environmental Other:
 Allergen(s): _____
 Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____
 Treatment prescribed: None Antihistimine Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Elevated Lead:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision one eye only One functioning kidney One testicle Concussion - Last occurrence: _____

PHYSICAL EXAMINATION

Height:	Weight:	BP:	Pulse:	Respirations:
Scoliosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive		Vision		
Degree of deviation: _____		Right		Left
Angle of trunk rotation via scoliometer: _____		Distance acuity		Referral
Weight Status Category (BMI Percentile):		Distance acuity with lenses		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <5th	<input type="checkbox"/> 85 th - 94 th	Vision - near vision		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 5 th - 49 th	<input type="checkbox"/> 95 th - 98 th	Vision - color perception		<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 50 th - 84 th	<input type="checkbox"/> 99 th & higher	Hearing		Right
		<input type="checkbox"/> 20 db sweep screen both ears or		Left
				Referral
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: I II III IV V

SYSTEM REVIEW AND EXAM ENTIRELY NORMAL Additional information attached

Specify any abnormalities: _____

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

- Full Activity** without restrictions including Physical Education and Athletics.
- Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.
 - No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
 - No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
 - Other Specific Restrictions:**

Accommodations / Protective Equipment:	<input type="checkbox"/> Athletic Cup	<input type="checkbox"/> Insulin Pump/Insulin Sensor	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Brace/Orthotic	<input type="checkbox"/> Medical /Prosthetic Device	<input type="checkbox"/> Sports Safety Goggles
	<input type="checkbox"/> Hearing Aides	<input type="checkbox"/> Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

- Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature: _____

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____	Date: _____
Provider Name: (please print) _____	Phone #: () _____
Provider Address: _____	Fax #: () _____

Return to:

School Nurse: _____	School: _____
Phone #: () _____	Fax: () _____
	Date: _____

Waterloo Central School District

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: _____

Birth Date:

Month

Sex: Male

Will this be your child's first visit to a dentist? Yes No

Day Year

Female

School: _____

Grade _____

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____

Date _____

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

Yes, The student listed above is in fit condition of dental health to permit him/her attendance at the public schools.

No, The student listed above is not in fit condition of dental health to permit him/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) _____

Dentist's Signature _____

Optional Sections - If you agree to release this information to school, parent please initial here.

II. Oral Health Status (check all that apply).

Yes No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

Yes No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.