Waterville Central School District
Memorial Park Elementary School
145 E. Bacon Street • Waterville, NY 13480

Mrs. Eleanor Petrie RN • *School Nurse* Phone: 315-841-3743 Fax: 315-841-3717

School Year 2013/2014

Dear Parent/Guardian;

New York State Education Law and regulations of the Commissioner of Education requires a physical examination of children when they are:

- **New entrant/transfer student**
- **In 2nd and 4th grade**
- **New entrant/transfer student entering 1st through 6th grade.**
- **Students in a BOCES class are required to have a yearly physical.**

The following forms are enclosed: Health History, Health Appraisal, Parental Permission, and Dental. The Physician completes the health appraisal. The health history and parental permission forms are completed by the parent/guardian. The dental form is completed by you and your Dentist. ***Please return these completed forms to the MPS Health Office as soon as possible. Do NOT send back forms that are not completed!***

Please complete the area below and return within two weeks time. If the form is not received in the Health Office within the two week time frame then a physical will be scheduled for your child by the School Nurse Practitioner at no cost to the parent/guardian.

Student Name_____. First and last name please.
GRADE_____ BOCES yes_____ no_____

1. **____ A current physical has been done. Make sure copy of a physical that was done is sent with this form.** ***New Students must have a physical completed within two weeks of starting school.***
2. **____ My child will have a physical done by their own Doctor on _____.**
   It is the parent's responsibility to make sure the physical is sent to Nurse Office. If it is not received within a week of noted date of exam, a physical will be scheduled for your child. .
   New Students must have a physical completed within two weeks of starting school.
3. **_____I authorize the School Nurse Practitioner to do a physical on my child.**

_____ _____
Parent/Guardian signature **Date**

Please call with any questions. Thank you for completing the above in a timely manner.

Sincerely,

Eleanor L. Petrie RN
Eleanor L. Petrie RN

Health History

Student's Name _____ Today's Date _____
Date of Birth ____/____/____ Sex M or F Telephone Number _____
Home Address _____
Parents/Guardian _____
Emergency Phone numbers Mother _____ Father _____

Allergies: (medications, foods, bees, environmental or other substances) Check if NO allergies ☐

_____

Does the child's allergy require immediate treatment with Epipen? Yes or No (Circle)
If yes, then a Doctor's order is needed on file and parents must supply the Epipen.

Medications: Does your child take any medication regularly? If so, please complete below.

	Name of Medication	Amount and how often taken
1.		
2.		
3.		

Hospitalization, Accidents, Broken Bones or Surgeries – Please list..

	Problem	Date	Age
1.			
2.			
3.			

Chronic Illnesses: Does your child have any illnesses that require medical attention?
If yes, please check below.

_____ Asthma
_____ Cancer
_____ Convulsions(epilepsy/seizures)
_____ Sickle Cell Anemia
_____ Cystic Fibrosis
_____ Diabetes
_____ Heart Disease
_____ Intestinal Disease
_____ Kidney Disease
_____ Liver Disease
_____ High Blood Pressure
_____ Hyperactivity
_____ HIV/AIDS
_____ Other_____

Past Illnesses and Health Problems: Has your child ever had any of the following?
Please check those problems.

_____ Overweight/underweight
_____ Skin Rashes
_____ Dizzy Spells or Fainting
_____ Frequent Ear Infections
_____ Frequent Nose Bleeds
_____ Meningitis
_____ Mononucleosis
_____ Pain in the chest
_____ Wheezing/Coughing
_____ Heart Trouble/Murmur
_____ Stomach Aches
_____ Pain in Back, Arms or Legs
_____ Concussions/Head Injury
_____ Tuberculosis
_____ Anemia
_____ Headaches
_____ Trouble seeing
_____ Problems with Teeth
_____ Trouble Hearing
_____ Hepatitis

- **Proof of Varicella (Chicken Pox) must be provided by Doctor.[proof of immunization, documented history of illness by Doctor, or positive blood titer result]**

In the event of an emergency, I authorize the school authorities to have my child transported to the nearest hospital where services of the staff physician on duty are engaged by me for the emergency. Preferred hospital _____ [To be determined by EMS and condition of student]

_____ **Date** _____
Signature of Parent/Guardian

This information will be shared, when necessary, for the health and safety of your child with appropriate school personnel.
Family Physician _____ **Phone** _____
Family Dentist _____ **Phone** _____

Please complete the back of form →

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Your Health Care Provider will require the release of information from below to share Protected Medical Information with your school district. Please sign and give the form to the school nurse to avoid delays. It may be shared with your Healthcare Provider.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I, _____, authorize my child's Healthcare Provider listed below to release my child's, _____, medical records to the district's School Nurse, and **those person's on a need to know basis** to ensure the safety of my child:

Doctor's Name_____ **Phone**_____
Fax_____
Specialist Name_____ **Phone**_____
Fax_____
Name_____ **Phone**_____ **Fax**_____

The HealthCare Provider may disclose the following protected health information:

- Immunizations.
- Health Appraisal/physical.
- Past/Current medical condition and its impact on attendance, school programming, and/or PT, OT, ST needs.
- Other.

The protected health information may be used, disclosed or received for the following purpose[s]:

- To develop care or therapy plans for routine and emergent school management.
- To design appropriate educational programs.
- To assess the impact of the medical condition[s] on school programming and/or attendance.
- To assess a medical basis for modification of transportation and/or home tutoring.
- At patient's request with no specific purpose.
- Other_____.

Please select one:

_____This authorization is valid for the entire academic school year 2013/2014
_____This authorization will expire on _____/_____/_____. [MO/DD/YR]

This authorization does not extend beyond current school year.

I acknowledge that I have the right to revoke this authorization at any time by sending in written notification to the School Nurse. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving any written revocation notice. I understand that any Protected Health Information disclosed as a result of the Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date **Signature of Patient [over age 18], Parent, or Guardian relationship**
YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: ☐ M ☐ F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

				Referral
Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category: (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

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Review of Systems

Eyes	
Ears (Otscopic)	
Lymph Nodes	
Thyroid	
Nose	
Tonsils	
Teeth	
Heart	
Lungs	
Hernia	
Lungs	
Hernia	
Genito-Urinary	
Tanner level	
Musculo-skeletal	
Feet	
Skin	
Nervous System	
Speech	
Other	

Notes: _____

Referral? _____

_____
Initials

Student Health Appraisal Supplement for Body Mass Index and Weight Status Reporting

This supplement should be completed and attached to student health appraisals for students in Kindergarten, 2nd, 4th, 7th or 10th grade. This information is required under New York State Education Law (Section 903) by the beginning of the 2008 academic school year.

Student Name: _____ **Date of Birth:** ____/____/____
First Last mm dd yyyy

Gender: ☐ **Male** ☐ **Female**

Grade (*Check One*): ☐ **Kindergarten** ☐ **2** ☐ **4** ☐ **7** ☐ **10**

Date of Measurement: ____/____/____
mm dd yyyy

Body Mass Index (BMI): ____ ____.____

Weight Status Category (Based on BMI percentiles for age and gender):

(Check ONE)

☐ Less than 5th
☐ 5th through 49th
☐ 50th through 84th
☐ 85th through 94th
☐ 95th through 98th
☐ 99th and higher

Specify current diseases (*Check ALL that apply*):

☐ Asthma
☐ Diabetes, Type 1
☐ Diabetes, Type 2
☐ Hyperlipidemia (High Cholesterol or Triglycerides)
☐ Hypertension (High Blood Pressure)

Dental Health Certificate- Optional

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: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

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

School: Name

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 his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/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 your child's school, 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 roof, 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.

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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the Licensed Health Care Prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis _____

Name of Medication _____

Prescribed dosage and route of administration _____

Frequency and time to be taken during school hours _____

Duration of treatment **2013/14 school year including summer school** _____

For PRN medications – list conditions under which medication should be administered:

_____

Name of Licensed Prescriber & Title [please print] _____

Prescriber's signature _____ **Phone** _____

Address _____

Date: _____

B. To be completed by parent or guardian:

I request that my child _____ grade _____, receive the medication as prescribed above by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. The medication expiration date must be good for the current year. I understand that the school nurse or licensed designee will administer the medication. Students determined to be self-directed may administer their own medication. Medications are maintained in the MPS Health Office.

The above medication is to be administered during the 2013/14 including summer school or until terminated by written notice.

Signature of Parent/Guardian _____

Address _____

Phone (home) _____ **Work** _____

Cell phone _____

Date _____