Dear Parent/Guardian:

As mandated by NY State Education Law, **all new registrants** and students in pre-kindergarten, **kindergarten** and grades **two, four**, seven and ten must have a physical examination given by a **New York State** licensed Health Care Provider. Students processed through the Committee on Special Education also require a physical examination upon entrance into the program and every three years as needed.
A physical examination at the designated grade level **must** take place whether it is given by the family health care provider or by the school physician.

The school health office will schedule your child for a physical examination by our district Health Care Provider upon your request. In the absence of a returned "Student Physical Examination" health form, your child will be scheduled automatically for a physical examination.

Health Care Providers are requested to use the "Student Physical Examination" health form enclosed with this letter, to summarize their report.

Please check the appropriate box below, sign ✍ your name, and return this completed form to your child's school Health Office.

- ☐ My child is scheduled for a physical examination by our Health Care Provider on (date) _____ by (name) _____
- ☐ My child may receive a school physical examination by the School Practitioner and/or School Physician.
- ☐ My child's Health Care Provider will fax _____ a copy of the physical to the Health Office.

Student Name: _____ **Grade**_____

Parent/Guardian Signature:_____ **Date:**_____

- Please complete and return this form to the Health Office.

Your cooperation is appreciated,

_____

School Nurse

St. Francis of Assisi School
70 Adams Street
Tonawanda, NY 14150
School Office 716-692-7886

HEALTH 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:	☐Positive	☐Negative	☐Not done	Date: _____
Dental Referral:	☐Positive	☐Negative	☐Not done	Date: _____

Significant Medical/Surgical History See Attached _____

Specify current disease: ☐Asthma Diabetes ☐Type 1 ☐Type 2 ☐Hyperlipidemia ☐ Hypertension

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

PHYICIAL EXAM

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

Body Mass Index: _____
Weight Status Category (BMI Percentile)
☐Less than 5th ☐5th through 49th ☐50th through 84th
☐85th through 94th ☐95th through 98th ☐99th and higher

			Referral
Vision- without glasses/contact lens	R	L	
Vision- with glasses/contact lens	R	L	
Vision- Near Point	R	L	
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 ☐Additions 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 parents to send in additional medication in the event of an emergency sheltering is necessary at school or if the morning medication has not been given.

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

☐Free from contagious & 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
☐Reactions: _____ ☐ Please Monitor
☐Protective equipment required: ☐Athletic Cup ☐Sport goggles/impact resistant eyewear ☐other: _____

(Stamp Below)

Provider's Signature: _____ Phone: _____

Provider's Name/ Address _____ Fax: _____

Parent's 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 Rev. 10/3/07

TONAWANDA CITY SCHOOL DISTRICT
DENTAL CERTIFICATE

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: 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).

☐☐ 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.

St. Francis of Assisi School
70 Adam Street, Tonawanda New York 14150
Office: (716)-692-7886

Immunization Records

Students Name: _____ Date: _____

	1st	2nd	3rd	4th	5th
DTP/DTaP					
Polio					
Hib					
Pneumococcal					
Varicella					
MMR					
Hep B					
Hep A					
Tdap					

Physician Name: _____

Physician Stamp/Signature: _____

Date: _____

New York State Immunization Requirements for School Entrance/Attendance

	Pre-Kindergarten * (Daycare, Nursery, or Pre K)	School (K – 12)
Diphtheria Toxoid Containing Vaccine (DTP, DTaP) **	3 doses (New York City Schools - 4 doses)	3 doses (New York City Schools – 4 doses)
Polio (IPV) (OPV)	3 OPV or 4 IPV	3 OPV or 4 IPV
Measles Mumps Rubella (MMR)	1 dose of Measles Mumps Rubella (MMR)	Born before 1985 – 1 dose of measles, mumps, rubella(MMR) Born on or after 1985 – 2 doses of measles containing vaccine and 1 dose each of mumps and rubella (preferably as MMR)
Hepatitis B ***	Born on or after 01/01/95 3 doses	(K-6) Born on or after 01/01/93 – 3 doses 7th Graders – Entering school on or after 9/01/2000 ***
Haemophilus Influenzae Type b (Hib)	3 doses or 1 dose administered on or after 15 months of age	Not Applicable
Varicella	Born on or after 1/1/2000**** 1 dose	Born on or after 1/1/98 1 dose

* Children in a Pre-Kindergarten setting need to be age appropriately immunized. The number of doses depends on the recommended schedule.

** DTaP is the currently recommended vaccine

*** Hep B – 7th Graders – 3 doses of RecombivaxHB, Engerix B or 2 doses of adult hepatitis B vaccine (Recombivax) for children 11 to 15 years old.

**** Varicella is not recommended until 1 year of age

New York City Department of Health, Bureau of Immunization, 2 Lafayette St., 19th Floor, New York, NY 10007 (212) 676-2273

New York State Department of Health, Bureau of Communicable Disease Control – Immunization Program, ESP, Corning Tower, Rm 649, Albany NY 12237 (518) 473-4437

Dear Parents of Fifth Graders,

There have been very recent changes in the **New York State Public Health Law immunization requirements** that are now in effect for your child.

One of these changes requires students **who were born on or after 1/1/1994, and who will be enrolled in the 6th grade in September of 20 _** to receive a booster vaccine called **Tdap**. This vaccine boosts protection against three diseases and is especially intended to drastically reduce the incidence of pertussis.

The school district will need to have a record of your child having received the **Tdap immunization**.

Please call your child's primary care physician **as soon as possible** to arrange a visit where your child can receive this required immunization.

Please return, mail or fax the lower portion of this form to me in the Health Office as soon as your child receives the immunization. Thank you for your prompt response. Please call the Health Office if you have any questions.

Sincerely,

_____, RN
School Nurse

STUDENT NAME _____ **DATE OF BIRTH** _____

TDAP IMMUNIZATION DATE _____

PRIMARY CARE PHYSICIAN NAME _____

PRIMARY CARE PHYSICIAN SIGNATURE _____ **DATE** _____