

THREE VILLAGE CENTRAL SCHOOL DISTRICT
ELEMENTARY PHYSICAL / HEALTH APPRAISAL

Name: _____ Gender: M F Date of Birth: _____

School: _____ Teacher: _____ Grade: _____

PHYSICAL EXAM

DATE OF EXAM: _____ ALLERGIES: _____

Height: _____ Weight: _____ Blood Pressure: _____ Resting Pulse: _____

REQUIRED:

Body Mass Index :

REQUIRED:

Weight Status Category (BMI Percentile):

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

REQUIRED:

SPECIFY CURRENT DISEASES:

ASTHMA DIABETES TYPE 1 DIABETES TYPE 2 HYPERLIPIDEMIA HYPERTENSION

AUDIOMETRY MUST INCLUDE VALUES:

AS 500	1000	2000	4000	Hz
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AUDIOMETRY MUST INCLUDE VALUES:

AD 500	1000	2000	4000	Hz
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Vision – <u>Uncorrected</u> :	R	L	Vision – <u>Corrected</u> :	R	L
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EXAM ENTIRELY NORMAL

URINALYSIS:

SPEC. GRAV	PRO.	GLUC.	MICRO
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Specify any abnormality:

MEDICAL	NORMAL	ABNORMAL FINDINGS	MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
NEUROLOGICAL			CONCUSSION	DATE:	
EYES / EARS			SCOLIOSIS / SPINE		
NOSE / THROAT			SHOULDER		
HEART / MURMUR			ARM		
LUNGS			HAND		
ABDOMEN			HIP		
GENITALIA			LEG		
SKIN					
HERNIA					
TEETH / MOUTH					

PHYSICAL EDUCATION / PLAYGROUND / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, playground, & school activities OR only as checked:

Specify medical accommodations needed for school: _____

Restrictions: _____

Provider's Signature: _____ Phone: _____ Fax: _____

Provider's Name/Address: _____ Stamp: _____

Parent Signature: _____ Parent Phone Number: _____ Date: _____

THREE VILLAGE CENTRAL SCHOOL DISTRICT IMMUNIZATION CERTIFICATE

Name of Student _____

Date of Birth _____

School _____

Grade _____

For vaccines given in combination, please list each component

DTaP

1	2	3	4	5
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Tdap

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DT or dT

1	2	3	4	5
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IPV

1	2	3	4	5
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HIB

1	2	3	4
---	---	---	---

VARICELLA

1	2
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Hx of Disease

Month	Year
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MMR

1	2
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MEASLES

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MUMPS

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RUBELLA

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HEPATITIS B

1	2	3
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HEPATITIS A

1	2
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GARDASIL

1	2	3
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MENACTRA

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SIGNATURE OF PHYSICIAN OR CERTIFYING AUTHORITY

DATE

STAMP

HEALTH HISTORY

Does your child have any of the following chronic health problems?

DIAGNOSIS	YES	NO	MEDICAL TREATMENT/MEDICATION DURING OR OUTSIDE THE SCHOOL DAY
DIABETES			
TUBERCULOSIS			
SEIZURES (ACTIVE/INACTIVE)			
CYSTIC FIBROSIS			
CEREBRAL PALSY			
ASTHMA			
RESPIRATORY DISORDER			
HEMOPHILLIA			
HEART CONDITION			
HEART MURMUR			
CANCER			
SKIN DISORDER			
HEPATITIS A			
HEPATITIS B			
OTHER			

Does your child:

1. Experience frequent absences due to illness? _____
2. Experience frequent hospitalizations? _____
3. Require special transportation, equipment, precautions in lifting or moving? _____
4. Other _____

Date _____ Signature of Parent/Guardian _____

THREE VILLAGE CENTRAL SCHOOL DISTRICT

Department of Health, Physical Education, Recreation and Athletics

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: / / Sex: Male
Month Day Year 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 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.

Dear Parent or Guardian:

Frequently the school nurse is asked to administer medication to a student during school hours. The Three Village School District will allow this under specific conditions. These conditions are:

1. A written request from a parent giving permission for administration of medication.
2. A written request must be submitted by the prescribing physician that includes the purpose of the medication, the dosage, the time at which or special circumstances under which medication shall be administered, the period for which medication is prescribed, and the possible side effects of the medication.
3. The medication must be in the original container identified for your child. The label must include name of doctor, name of the student, name of the medication, amount to be administered and when it is to be administered.
4. Only an adult may transport the medication to the Health Office, and only an adult may pick up any remaining medication at the end of the school year, or the end of the period of administration, whichever is earlier. All medication not picked up within five days of the period of administration will be discarded.

Students **will not** be permitted to take any medication if the established procedures are not followed. This includes over the counter drugs such as Tylenol, aspirin, throat spray, etc.

It is the responsibility of the student to report to the Health Office at the prescribed time for the purpose of receiving the medication.

This procedure must be repeated at the beginning of each school year whenever there is a case of continued need for medication.

If you have any questions concerning our district policy, please feel free to call 730-4210 any time.

Sincerely,

Nancy Weiner, R.N.
School Nurse

THREE VILLAGE CENTRAL SCHOOL DISTRICT

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in properly labeled original container from the pharmacy. I understand that the school nurse or other designated person in the case of the absence of the school nurse will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by the physician:

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency & Route of Administration: _____

Time to be taken during the school hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations: _____

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Name of Physician (please print): _____

(If authorization is signed by a Physician Assistant or Nurse Practitioner, the name of the supervising physician must be indicated).

Signature: _____

Date: _____

Address: _____

Phone: _____