



*The mission of the Three Village Central School District, in concert with its families and community, is to provide an educational environment which will enable each student to achieve a high level of academic proficiency and to become a well-rounded individual who is an involved, responsible citizen.*

**THREE VILLAGE**  
CENTRAL SCHOOL DISTRICT

**Paula Bienia, Principal**  
**Patricia Essinfeld, Assistant Principal**

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**Minnesauke Elementary School**

**Dear Parent or Guardian:**

**Welcome new students and their families from the Minnesauke health office.**

**In this letter you will find forms labeled:**

**Elementary health appraisal**  
**BMI, immunization**  
**Family health history**  
**Administration of Medication**  
**Emergency Contact Card**  
**Information Sheets**

**Please be sure to pay particular attention to the requirements regarding immunizations and physical exam.**

**I look forward to seeing you at the kindergarten screening.**

**Sincerely,**

**Nancy Weiner, R.N.**  
**School Nurse**

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21 High Gate Drive ■ East Setauket, New York 11733 ■ Telephone: 631-730-4200

Donald F. Webster., **Interim Superintendent of Schools**

**Assistant Superintendents:** Cheryl Pedisich, Educational & Pupil Personnel Services ■ Jeffrey Carlson, Business Services ■ B. Allen Mannella, Interim Human Resources

**\*\*\* FOR INCOMING KINDERGARTEN STUDENTS\*\*\***

**THE FOLLOWING INFORMATION IS PAPERWORK THAT NEEDS TO BE COMPLETED BY THE PARENT/GUARDIAN AS WELL; AS YOUR CHILD'S PHYSICIAN. ANY QUESTIONS CAN BE ADDRESSED TO THE SCHOOL NURSE AT YOUR CHILD'S SCREENING DATE.**

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**HEALTH HISTORY- must be completed and signed and returned at screening**

**EMERGENCY CONTACT CARD – This temporary sheet must be completed, signed and returned at screening. It must include your home phone number, business, and beeper and/or cell phone numbers. The school must be provided with at least two local neighbors or relatives who will accept the responsibility for your child in the event you cannot be reached. It is your responsibility to notify the health office of any change or addition of information to the card. A hard copy of the emergency contact card will be sent home at the start of the school year for you to complete.**

List any additional family and friends that you are authorizing to pick up your child during the school day; as well as dismissal time. Please send in a note to your child's teacher if you are planning to pick him/her up early and give authorization that someone else will be signing out your child.

**PLEASE HAVE YOUR CHILD'S DOCTOR COMPLETE THE FOLLOWING FORMS**

**IMMUNIZATION CERTIFICATE - Please review the enclosed memo from New York State Department of Health regarding the immunizations that are required by the State entrance into school. Proof of the completed immunizations must be presented to the health office prior to the first day of school. State Law requires the district to exclude students who have incomplete immunizations.**

**ELEMENTARY HEALTH APPRAISAL - New York State Education Law requires a physical examination for all new entrants to the school district. The Elementary Health Appraisal must be signed, stamped and dated by the physician, physician assistant or nurse practitioner.**

**BMI FORM (BODY MASS INDEX) Required by New York State**

**ADMINISTRATION OF MEDICATION – SUBMIT ONLY if your child requires medication during the school day. The administration of Medication form needs to be filled out by you and your child's physician for each medication and returned to the health office. This applies to both prescription and over the counter medications. The medication, in its original container, must be brought to the health office by a parent or guardian. Medication is not to be carried by your child. According to state law, medication cannot be administered if these requirements are not met.**

**DENTAL FORM – To be filled out by your child's dentist**

**In order to achieve a better understanding of the health services, the following is a partial explanation of what we are doing and what you as parents or guardians can do to make our efforts more effective.**

**FIRST AID:**

**In case of an injury the nurse will administer first aid. If the injury is severe and a parent cannot be reached, the school will call 911.**

**SUDDEN ILLNESS:**

**If a child becomes sick in school, a parent will be called to come to school to take the child home. In the event a parent cannot be reached, the emergency contact people will be called and asked to come for your child.**

**SCREENING:**

**Vision and hearing screening, as well as height and weight, will be done during the school year. You will be notified of any problems. Any findings and recommendations by your child's physician should then be reported back to the school health office.**

**OUTDOORS DRESS:**

**Children should be dressed appropriately for the weather and expected to be outdoors at recess when the temperature is above twenty degrees and there is no precipitation.**

**CALLING IN ABSENCES:**

**Please notify the health / attendance office, when your child is going to be absent from school. For your convenience, our voice mail is on at all times. If you do not call in, you will receive a message requesting that you call us back regarding your child's absence. An absence note to your child's teacher is also required upon their return to school.**

**Office number... 730-4210**

**Fax number.....730-4213**

**E-mail [nweiner@3villagecsd.k12.ny.us](mailto:nweiner@3villagecsd.k12.ny.us)**

**Immunization Requirements for School Entrance and Attendance**

**NEW YORK STATE DEPARTMENT OF HEALTH BUREAU  
OF COMMUNICABLE DISEASE CONTROL IMMUNIZATION PROGRAM**

**The following vaccines are required for a child to attend school:**

- \* 3 doses of diphtheria - containing toxoid (usually administered as DPT, DT or TD).**
- \* 3 doses of oral polio vaccine (OPV) or enhanced inactivated poliovirus vaccine (EIPV).**
- \* 1 dose of mumps vaccine administered on or after 12 months of age.**
- \* 1 dose of rubella vaccine administered on or after 12 months of age.**
- \* 2 doses of measles vaccine, first dose administered on or after 12 months of age and the second dose recommended to be administered at 4 to 6 years of age and required for kindergarten entry.**
- \* 3 doses of hepatitis B vaccine**
- \* 1 dose of varicella vaccine, first dose administered on or after 12 months of age or documentation by the physician stating that your child had the disease.**

**Religious or medical exemptions to these requirements must be submitted to Ms. Erin Blaney, Director of Health, PE, Recreation and Athletics in writing.**

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**THREE VILLAGE CENTRAL SCHOOL DISTRICT**  
**Setauket, New York 11733**

**ELEMENTRY HEALTH APPRAISAL**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_

IMMUNIZATION: (If indicated) \_\_\_\_\_  
 TYPE DATE TYPE DATE TYPE DATE

DATE OF EXAM \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SEX \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ RESTING PULSE \_\_\_\_\_

HEAD \_\_\_\_\_ NECK \_\_\_\_\_ MOUTH \_\_\_\_\_ TEETH (APPLIANCE) \_\_\_\_\_

THROAT \_\_\_\_\_ CHEST \_\_\_\_\_ HEART \_\_\_\_\_ GENITALIA \_\_\_\_\_

ABDOMEN \_\_\_\_\_ EXTREMITIES \_\_\_\_\_

BACK \_\_\_\_\_ SCOLIOSIS \_\_\_\_\_ SKIN \_\_\_\_\_ NEUROLOGICAL \_\_\_\_\_

**AUDIOMETRY:**

AS 500	1000	2000	40000	Hz	AD 500	1000	2000	4000	Hz
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**VISUAL ACUITY UNCORRECTED: (If Indicated)**

OS	OD	OU	COLOR DISCRIMINATION
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**VISUAL ACUITY CORRECTED: (If Indicated)**

OS	OD	OU	COLOR DISCRIMINATION
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**URINALYSIS:**

URINALYSIS:				PPD		HGB/HCT	
SPEC. GRAV.	PRO.	GLUC	MICRO	DATE	RESULT	DATE	RESULT

ANY RESTRICTION OF ACTIVITIES: YES \_\_\_\_\_ NO \_\_\_\_\_ (Please check one)

IF YES, EXPLAIN:

\_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE OF PHYSICIAN M.D. STAMP

\_\_\_\_\_  
 DATE TELEPHONE NUMBER



## 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
---	---	---	---	---

IPV

1	2	3	4	5
---	---	---	---	---

HIB

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

VARICELLA

1	2
---	---

Hx of Disease

Month	Year
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MMR

1	2
---	---

MEASLES

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MUMPS

--	--

RUBELLA

--	--

HEPATITIS B

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

HEPATITIS A

1	2
---	---

GARDASIL

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

MENACTRA

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\_\_\_\_\_  
SIGNATURE OF PHYSICIAN OR CERTIFYING AUTHORITY

\_\_\_\_\_  
DATE

STAMP

# 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  Female Will this be your child's first visit to a dentist?  Yes  No  
Month Day Year

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

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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.



## 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:

Experience frequent absences due to illness? \_\_\_\_\_

Experience frequent hospitalizations? \_\_\_\_\_

Require special transportation, equipment, precautions in lifting or moving? \_\_\_\_\_

Other \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

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: \_\_\_\_\_

=====

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: \_\_\_\_\_

Dear Parents/Guardians:

The **Emergency Contact Card** is very important, as we use it to help us carry out your wishes in the event of an emergency during the school day. If a child becomes ill while at school we count on the emergency contact card for information needed to release your child from school. A hard copy will be sent home with your child the first week of school.

Please take time when filling out the card to list all numbers that we can use to reach you including work, cell, and beeper numbers. When noting friends or relatives who can be contacted when we cannot reach you, please make sure the people you list are readily available. The individuals should live locally and know you have listed them to pick your child up and care for him/her in the event of illness.

Occasionally an emergency early dismissal may be necessary. This is usually associated with a weather problem. News of early an closing is posted on the radio. The district calendar lists radio stations to consult. At the beginning of each year it is wise to make emergency plans and discuss them at home.

Thank you for your time and attention to this matter.

Sincerely,

Paula Bienia  
Principal

# EMERGENCY CONTACT CARD FOR ONLY TO BE USED FOR INCOMING KG

Three Village Central School District

Elementary

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_ Teacher: \_\_\_\_\_ Room: \_\_\_\_  
(Last Name) First Name mm dd yyyy

Name(s) of Parent or Guardian(s): 1. \_\_\_\_\_ 2. \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Cell Phone: \_\_\_\_\_ Mother's Beeper: \_\_\_\_\_

Father's Cell Phone: \_\_\_\_\_ Father's Beeper: \_\_\_\_\_

Primary e-mail contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary e-mail contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent's Place of Employment (please include city):

Mother: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Work Place: \_\_\_\_\_

Step Parent(s): 1. \_\_\_\_\_ 2. \_\_\_\_\_

(Name) (Phone number) (Name) (Phone Number)

(Please indicate if step parent is an emergency contact)

If the school cannot contact either parent, please name two local relatives/friends who may be called upon to assume responsibility if child is ill or injured.

Transportation of an ill or injured child is to be arranged by parent or persons named below. Please feel free to add additional names to the back of the card.

Anyone not listed as an emergency contact will not be permitted to pick up the child.

Name/Relationship: \_\_\_\_\_ Name/Relationship: \_\_\_\_\_

Address (Town/Village): \_\_\_\_\_ Address (Town/Village): \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_ Telephone Number(s): \_\_\_\_\_

Physician to be called in an emergency (local): \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Dentist to be called in an emergency (local): \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Please list any severe allergy or medical condition(s): \_\_\_\_\_

Please list any injury or hospitalization (with dates) student has had in the past year: \_\_\_\_\_

Please list student's current medications: \_\_\_\_\_

**New York State Law requires children entering Kindergarten and new entrants to be examined by their family physician and a report submitted before entering District Schools. Physical exams are also required in grades 2, 4, 7 and 10. It is recommended that this be done by your family physician. Children who do not submit a Physical report will be seen by the school physician.**

**\*The parent/guardian is responsible for notifying the school of any changes in the above stated information.**

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

## **Names of Additional Emergency Contacts**

Name/Relationship: \_\_\_\_\_ Name/Relationship: \_\_\_\_\_

Address (Town/Village): \_\_\_\_\_ Address (Town/Village): \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_ Telephone Number(s): \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Name/Relationship: \_\_\_\_\_

Address (Town/Village): \_\_\_\_\_ Address (Town/Village): \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_ Telephone Number(s): \_\_\_\_\_