

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

Health and Dental Examination Requirements

Dear Parent or Guardian :

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th and 11th grade**. The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school and when your child starts Pre-K or K, 1st, 3rd, 5th, 7th, 9th & 11th grades, If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care providers can be found at <https://www.voorheesville.org/Page/432>
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed or emailed.

Please call the school's Health Office if you have any questions or concerns.

Megan Pooler, RN – Middle/High School (518) 765-3314 ext 210

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Colleen Brackett, RN – Elementary School (518) 765-2382 ext 506

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| | |
|-------|------|
| Name: | DOB: |
|-------|------|

SCREENINGS

| Vision | Right | Left | Referral | Notes |
|--|--------------------------|--------------------------|--|-------|
| Distance Acuity | 20/ | 20/ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Distance Acuity With Lenses | 20/ | 20/ | | |
| Vision – Near Vision | 20/ | 20/ | | |
| Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail | | | | |
| Hearing | Right dB | Left dB | Referral | |
| Pure Tone Screening | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Scoliosis | Negative | Positive | Referral | |
| Required for boys grade 9 And girls grades 5 & 7 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Deviation Degree: | | Trunk Rotation Angle: | | |

Recommendations:

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

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications

No Contact Sports **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

No Non-Contact Sports **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY
 Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports
 Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

| | | |
|---|---|---|
| <input type="checkbox"/> Brace*/Orthotic | <input type="checkbox"/> Colostomy Appliance* | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Insulin Pump/Insulin Sensor* | <input type="checkbox"/> Medical/Prosthetic Device* | <input type="checkbox"/> Pacemaker/Defibrillator* |
| <input type="checkbox"/> Protective Equipment | <input type="checkbox"/> Sport Safety Goggles | <input type="checkbox"/> Other: |

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

Order Form for Medication(s) Needed at School attached

| | | |
|---------------------------------|--|--|
| List medications taken at home: | | |
| | | |

IMMUNIZATIONS

Record Attached Reported in NYSIS Received Today: Yes No

HEALTH CARE PROVIDER

| | |
|--------------------------------------|--------------|
| Medical Provider Signature: | Date: |
| Provider Name: <i>(please print)</i> | Stamp: |
| Provider Address: | |
| Phone: | |
| Fax: | |

Please Return This Form To Your Child's School When Entirely Completed.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY 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, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

| | | |
|---------|--|------------|
| Name: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | DOB: |
| School: | Grade: | Exam Date: |

HEALTH HISTORY

| | | |
|---|--|--|
| Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental | <input type="checkbox"/> Anaphylaxis Care Plan Attached |
| Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____ | <input type="checkbox"/> Asthma Care Plan Attached |
| Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____ | <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____ |
| Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____ | <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached |
| Risk Factors for Diabetes or Pre-Diabetes: <i>Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.</i> | | |
| BMI _____ kg/m2 Percentile (Weight Status Category): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and > | | |
| Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

PHYSICAL EXAMINATION/ASSESSMENT

| | | | | |
|---|---|--|---------------------------------------|---|
| Height: | Weight: | BP: | Pulse: | Respirations: |
| TESTS | Positive | Negative | Date | Other Pertinent Medical Concerns |
| PPD/ PRN | <input type="checkbox"/> | <input type="checkbox"/> | | One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle |
| Sickle Cell Screen/PRN | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Concussion – Last Occurrence: _____ |
| Lead Level Required Grades Pre- K & K | | | Date | <input type="checkbox"/> Mental Health: _____ |
| <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated > 10 µg/dL | | | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> System Review and Exam Entirely Normal | | | | |
| Check Any Assessment Boxes <u>Outside</u> Normal Limits And Note Below Under Abnormalities | | | | |
| <input type="checkbox"/> HEENT | <input type="checkbox"/> Lymph nodes | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Extremities | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Back/Spine | <input type="checkbox"/> Skin | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Lungs | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations: | | | Diagnoses/Problems (list) | ICD-10 Code |
| | | | _____ | _____ |
| | | | _____ | _____ |
| | | | _____ | _____ |
| <input type="checkbox"/> Additional Information Attached | | | | |

