### 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, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup> and 11<sup>th</sup> 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, 1<sup>st</sup>, 3rd, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup> & 11<sup>th</sup> 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 <a href="https://www.voorheesville.org/Page/432">https://www.voorheesville.org/Page/432</a>
- 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

mpooler@voorheesville.org fax (518) 765-5547

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

cbrackett@voorheesville.org fax (518)765-3842

Name:				DOB:
		SCREENING	S	
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
/ision – Near Vision	20/	20/		
/ision – Color □ Pass □ Fail	7121			
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	Negative	Positive	Referral	
And girls grades 5 & 7			☐ Yes ☐ No	
Deviation Degree:		Trunk Rotatio	on Angle:	
Recommendations:		-fi-5		
RECOMMENDATIONS FO	OR PARTICIPAT	ION IN PHYSICA	L EDUCATION/SPO	RTS/PLAYGROUND/WORK
☐ Full Activity without restricti	ons including Ph	ysical Education	and Athletics.	
Restrictions/Adaptations	_	·		for Restrictions or modifications
☐ No Contact Sports	<b>Includes:</b> ba	aseball, basketbal	l, competitive cheerl	eading, field hockey, football, ice
	•	· ·	ball, volleyball, and v	_
☐ No Non-Contact Sports		•	-	intry, fencing, golf, gymnastics, rif
	Skiing, swir	nming and diving,	tennis, and track &	field
Other Restrictions:	Lui al	0.11.1		
Developmental Stage for Atl			معمد المنابات وعاوم والباداء	
Grades 7 & 8 to play at high so Student is at <b>Tanner Stage:</b>			nidale school level spo	orts
Student is at Taimer Stage.				
Accommodations: Use addit				
	tional space belo	ow to explain	nce*	☐ Hearing Aids
☐ Brace*/Orthotic	tional space belo	ow to explain Colostomy Applia		☐ Hearing Aids ☐ Pacemaker/Defibrillator*
<ul><li>☐ Brace*/Orthotic</li><li>☐ Insulin Pump/Insulin Ser</li></ul>	tional space belo () () () () ()	ow to explain Colostomy Applia Medical/Prosthet	ic Device*	☐ Pacemaker/Defibrillator*
<ul><li>☐ Brace*/Orthotic</li><li>☐ Insulin Pump/Insulin Ser</li><li>☐ Protective Equipment</li></ul>	tional space belo ( ) ( ) ( ) ( ) ( )	ow to explain Colostomy Applia Medical/Prosthet Sport Safety Gog	ic Device* gles	<ul><li>□ Pacemaker/Defibrillator*</li><li>□ Other:</li></ul>
<ul><li>☐ Brace*/Orthotic</li><li>☐ Insulin Pump/Insulin Ser</li><li>☐ Protective Equipment</li></ul>	tional space belo ( ) ( ) ( ) ( ) ( )	ow to explain Colostomy Applia Medical/Prosthet Sport Safety Gog	ic Device* gles	<ul><li>□ Pacemaker/Defibrillator*</li><li>□ Other:</li></ul>
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# 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).

Committee on Pre-School Special education (CPSE).								
			STU	JDENT INFORMATI	ON			
Name:						Sex: 🗆 M 🔲 F	DOB:	
School:						Grade:	Exam Date:	
HEALTH HISTORY								
Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached					n Attached			
☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental								
Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached								
☐ Yes, indicate type	☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other :							
Seizures   No	□ Medio	cation/Treatn	nent Orde	r Attached	☐ Seizur	e Care Plan Atta	ached	
☐ Yes, indicate type								
r								
	ĺ			er Attached		_		
Risk Factors for Diabet			: ⊔ H¤	Alc results:	L	pate Drawn:		
Consider screening for			and has 2	or more risk factors:	Family Hx T2	DM, Ethnicity, S	x Insulin Resistance,	
Gestational Hx of M				-				
BMIkg/m	2 Percei	ntile (Weight	Status Cat	egory): 🗆 <5 <sup>th</sup> 🗖 5	th-49th 50t	h-84 <sup>th</sup> <b>185</b> th-94	<sup>th</sup> □ 95 <sup>th</sup> -98 <sup>th</sup> □ 99 <sup>th</sup> ar	ıd>
Hyperlipidemia: 🔲 N	lo □Ye	s I	Hypertensi	on: ☐ No ☐ Yes				
per la persona			PHYSICAL	EXAMINATION/AS	SESSMENT	Time Tax on July 1		
Height: BP: Pulse:					Respirations:			
TESTS	Positive	Negative	Date		Other Perti	nent Medical C	oncerns	un;
PPD/ PRN				One Functioning:	•	•		
Sickle Cell Screen/PRN				Concussion – Las				
Lead Level Required Grades Pre- K & K Date								
☐ Test Done ☐ Lead Elevated ≥ 10 μg/dL ☐ Other:  ☐ System Review and Exam Entirely Normal								
Check Any Assessment Boxes <i>Outside</i> Normal Limits And Note Below Under Abnormalities								
	Lymph no		☐ Abdo		☐ Extremit	ĩ	☐ Speech	
				Back/Spine			☐ Social Emotional	
□ Neck □	The state of the s			☐ Neurolo	gical	☐ Musculoskeletal		
☐ Assessment/Abnormalities Noted/Recommendations:					Diagnoses/Problems (list) ICD-10 Code			
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### VOORHEESVILLE CENTRAL SCHOOL DISTRICT

#### **Dental Health Certificate**

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Sectio	n 1. To be comple	eted by Parent	or Guardian (Please Pri	int)		
Child's Name:		First	Middle			
Birth Date: / /  Month Day Year	Sex: ☐ Male ☐ Female	Will this be your o	hild's first oral health assessme	ent? □ Ye	es 🗆 No	
School: Name	□ remale				Grade	
Have you noticed any problem in the mou	ith that interferes with y	our child's ability to	chew, speak or focus on schoo	ol activities?	☐ Yes ☐ No	
I understand that by signing this form I an assessment is only a limited means of every child to receive a complete dental exal I also understand that receiving this prelin Further, I will not hold the dentist or those recommendations listed below.	aluation to assess the s mination with x-rays if a ninary oral health asses	student's dental hea necessary to mainta ssment does not es	Ith, and I would need to secure in good oral health.  ablish any new, ongoing or con	the services	of a dentist in order for r-patient relationship.	
Parent's Signature			Date	e		
Sec	tion 2. To be com	pleted by the D	Dentist/ Dental Hygienis	t		
I. The dental health condition ofdate of the assessment needs to b  Yes, The student listed above is in  No, The student listed above is not not not not in fit condition of dental hon school activities including pain, sw condition of dental health to permit at	n fit condition of dent of in fit condition of de ealth means, that a de welling or infection re ttendance at the pub and address	tal health to permi ental health to pe condition exists th lated to clinical ev	t his/her attendance at the p mit his/her attendance at th at interferes with a student's vidence of open cavities. Th	is requested bublic school e public school s ability to clare designation attending s	ls. nools. hew, speak or focus on of not in fit chool.	
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 If retained root, assume that the considered sound unless a cavi	the lesion. These crite whole tooth was destr	ria apply to pits and royed by caries. Bro	fissure cavitated lesions as well	II as those or	smooth tooth surfaces.	
Other problems (Specify):						
II. Treatment Needs (check all t	hat apply)					
□ No obvious problem. Routine dent	al care is recommen	ided. Visit your de	entist regularly.			
☐ May need dental care. Please sch	nedule an appointme	ent with your denti	st as soon as possible for ar	n evaluatior	1.	
Immediate dental care is required.	Please schedule ar	n appointment imi	nediately with your dentist to	o avoid prob	olems.	