MEDICAL AND DENTAL EXAMINATION FORMS

Dear Parents/Guardians:

New York State Education Law requires that all students in public schools be examined by a health care provider upon entrance into school and in Pre-Kindergarten, Kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th grades. While the law does not specifically require an examination in other grades, we encourage annual physical examinations. Enclosed you will find a Health Examination Form that may be used by your own physician, physician assistant, or nurse practitioner licensed to practice in New York State. Please return it along with a current immunization record.

Health examinations include height and weight measurement. These numbers are used to determine body mass index or “BMI.” Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student’s health examination. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting summary information to the New York State Department about our students’ weight status groups. Information about individual students and student names are not provided. However, you may still choose to have your child’s information excluded from this survey report by written request to me or your child’s school nurse by the last day in September.

Enclosed you will also find a Dental Examination Form. Both the medical and dental forms should be returned to school as soon as possible. These forms are acceptable for the current school year if the examination date is no longer than 12 months prior to the 1st day of school in September.

Best wishes for a happy and healthy summer.

Sincerely,

Jill DeRosa, Ed.D.
Assistant Superintendent for Human Resources, Student Services and Community Activities

Distribution: New students and all students entering Pre-Kindergarten, Kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th.
HEALTH APPRAISAL FORM

Name: _____________________________ Date of Birth: _____________________________

School: ___________________________ Gender: □ M □ F Grade: __________________________

IMMUNIZATIONS / HEALTH HISTORY

☐ Elevated Lead □ Yes □ No □ Not done Date: _____________________________

☐ PPD □ Positive □ Negative □ Not done Date: _____________________________

☐ Sickle Cell Screen □ Positive □ Negative □ Not done Date: _____________________________

☐ Immunization record attached

Significant Medical/Surgical History: ☐ See attached

Specify current diseases: ☐ Asthma ☐ Diabetes: □ Type 1 □ Type 2 ☐ Hyperlipidemia ☐ Hypertension

☐ Other: _____________________________

Allergies: ☐ LIFE THREATENING ☐ Food: _____________________________

☐ Insect: _____________________________ □ Other: _____________________________

☐ Seasonal ☐ Medication: _____________________________

PHYSICAL EXAM

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

Body Mass Index: _______________ - _______________  Vision: without glasses/contact lenses  R  L

Weight Status Category (BMI Percentile):
☐ less than 5th  ☐ 5th through 49th  ☐ 50th through 84th ☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher  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 ☐ Additional 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 parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

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

☐ Limited contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, tennis, archery, rifle, weight train, crew, dance, track, run, walk, rope jump.

☐ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, rifle, weight train, crew, dance, track, run, walk, rope jump.

☐ Specify medical accommodations needed for school: _______________

☐ Known or suspected disability: _______________

☐ Restrictions: _______________

☐ None

☐ Please monitor

(Provider's Stamp below)

Provider's Signature: _____________________________ Phone: _____________________________

Provider's Name/Address: _____________________________ Fax: _____________________________

Parent Signature: _____________________________ Date: _____________________________

NYSED requires an annual physical exam for new entrants and students entering Kindergarten, 2nd, 4th, 7th and 10th grades.
DENTAL EXAMINATION FORM

Child’s Name ________________________________

School __________________ Grade _________

Teacher’s Name ____________________________

Dental Examination Date ____________________

Comments __________________________________

__________________________________________________________________________

Dentist Signature ____________________________

Dentist Stamp