

NORTH COLONIE CENTRAL SCHOOLS
91 FIDDLERS LANE
LATHAM, NEW YORK 12110

Dear Parents:

Changes in New York State Education Law (Sept. 08) requires that each student receive a physical as well as a comprehensive dental exam when **entering a school district for the first time** and again in **grades K, 2, 4, 7, 10**. While these examinations can be administered by the school physician and we will have a list of local dentists, we urge you to use your family physician/dentist for this purpose during your child's summer vacation. In this manner, a pattern of consistent, optimum health care can be established.

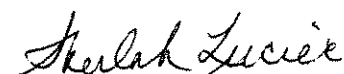
If your child has recently seen your family physician/dentist and will be a beginning **Kindergartner, 2nd, 4th, 7th, or 10th grader** in September, please ask the doctor to complete the reverse side of this form as well as the dental form. Although the forms **must be** returned by the end of September, an examination administered not more than twelve months prior to commencement of the school year in which the examination is required, will be accepted. For those beginning **Kindergartners, 2nd, 4th, 7th and 10th** graders who have not received examinations from a private physician by September, a visit to our school physician will be scheduled in the fall.

Again, please return this form to your school nurse by the **end of September**. You are reminded of the following:

1. To notify us if it is necessary for your child to be absent due to illness
Call the school the first day of absence.
2. To keep us informed during the school year on items below (changes)
3. When the annual school health appraisals are made, you will be notified if any abnormalities are found.

Please feel free to call us or send a note if we may be of assistance to you at any time.

Sincerely yours,



Sheelah Lucier
Director of Pupil Services

To be completed by Parent:

Name of Pupil _____		Grade _____	Teacher _____
Mailing Address _____		Telephone _____	
Parent/Guardian (home) _____	(work) _____		
Parent/Guardian (home) _____	(work) _____		
Names of person, other than parents, to be called in case of emergency if neither parent can be reached			
1. Name _____	Address _____	Hm. Tel. _____	Wk. Tel. _____
2. Name _____	Address _____	Hm. Tel. _____	Wk. Tel. _____
Family Physician _____	Address _____	Phone # _____	
Family Dentist _____	Address _____	Phone # _____	
Medical Problems _____			
Date _____	Parent's Signature _____		
1/09DJD			

North Colonie Central School District
HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ SPORTS TO BE PLAYED: _____

School: _____ Gender: M F Grade _____ Date of Birth: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal:

Sickle Cell Screen: Positive Negative Not done Date: _____
PPD: Positive Negative Not done Date: _____
Elevated Lead: Yes No Not done Date: _____
Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

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

Referral

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> 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 list on additional 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: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

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

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

Dental Health Certificate North Colonie Central School District

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: _____		
<small>Last</small>	<small>First</small>	<small>Middle</small>
Birth Date: / / <small>Month Day Year</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
School: <small>Name</small> _____		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.