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

Dear Parents:

New York State Education Law requires that each student receive a physical exam when **entering a school district for the first time** and again in **grades K, 2, 4, 7, 10.** This law also requests a comprehensive dental exam. While the physical examination can be administered by the school physician, and we can offer you names of dentists in the community; 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.

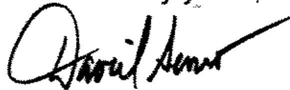
If your child has recently seen your family physician/dentist and will be a beginning **Kindergartner, 2nd, 4th, 7th, or 10th grader** in September, please ask the doctor to complete the reverse side of this form as well as the dental form. Although the forms must be returned by the end of September, 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,



Mr. David Semo
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________________

1/10 DJD/appMBS

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

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: ________

Body Mass Index: ____ ____ . ____	Vision - without glasses/contact lenses	R	L	*Referral*
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❏ less than 5th ❏ 5th through 49th ❏ 50th through 84th	Vision - Near Point	R	L	
❏ 85th through 94th ❏ 95th through 98th ❏ 99th and higher	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 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: ____________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 1/09DJD*

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: Last First Middle

Birth Date: / / (Month Day Year)

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

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

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.