Sweet Home Central School District

of Amherst and Tonawanda

PARENT LETTER FOR MANDATED PHYSICAL EXAMINATION HF-01a-r
Rev. 06-13

Dear Parent/Guardian:

As mandated by New York State Education Department Commissioner's Regulations for School Health Services [Section 136 CR 136.3], all **new registrants** and students in **pre-kindergarten, kindergarten and grades two, four, seven and ten** must submit a health certificate upon his or her entrance to school. Students processed through the **Committee on Special Education** also require a health certificate upon entrance into the program and every three years as needed.

Health Care Providers are requested to use the *Health Appraisal* Form (HF- 1a) on the reverse side of this memo to summarize their report. Physical examination reports/health certificates must be **submitted within the first week of school attendance**. 'Each such certificate shall describe the condition of the student when the examination was made, which **shall not be more than 12 months prior to the commencement of the school year** in which the examination is required, and shall state whether such student is in a fit condition of health to permit his or her attendance at the public school.'

A physical examination upon entry or at the designated grade level must take place whether it is given by the family health care provider or by school personnel. If a required health certificate is not submitted, a notice will be sent to the student's parent or guardian stating that if the health certificate is not furnished within 30 days from the date of the notice, a school physician or nurse practitioner will make an examination of the student.

Parents will be notified by school health personnel in writing of any apparent or possible defect found through any school examination/screening.

Thank you for your cooperation. Please contact your building School Nurse if you need further information.

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).

SWEET HOME CENTRAL SCHOOL DISTRICT
HEALTH CERTIFICATE / APPRAISAL FORM

HF 01a 6-13

Name: ____________________ **Date of Birth:** ____________________

School: ____________________ **Gender:** ☐ M ☐ F **Grade/HR:** ____________________

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: __________
Last Dental Health Exam Date: ______ Dentist Name: __________

Significant Medical/Surgical History: ☐ See attached ____________________

Allergies: ☐ LIFE THREATENING ☐ Food ☐ Insect ☐ Seasonal ☐ Other ____________________

☐ Allergy Medication Required: ____________________

Specify Current Diseases: ☐ Asthma ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Hyperlipidemia ☐ Hypertension ☐ Seizures __________

History: ☐ Chest Pain ☐ Fainting ☐ Heart Disease ☐ Lung Disease ☐ Kidney Disease ☐ Other __________

Family History: ☐ Sudden Death from Heart Disease at a Young Age ☐ No ☐ Yes If yes, specify __________

History of Concussion: ☐ No ☐ Yes If yes, please state date(s) and details __________

PHYSICAL EXAM

Date of Exam: __________

Height: ________ Weight: ________ Blood Pressure: ________ Pulse: ________ Temp.: ________ LMP: ________

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. Dental Referral: ☐ Yes ☐ No

Scoliosis: ☐ Negative ☐ Positive: ____________________ ☐ Refer for Xray

Specify any abnormality: ____________________

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications- please attach to this 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, fence, baseball, floor hockey, softball.
☐ Non-contact: badminton, bowling, 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: __________

HEALTH CARE PROVIDER INFO

Provider's Signature: ____________________ Phone: __________ FAX: __________

Health Care Provider Stamp

Provider's Name/Address: ____________________

Parent/Guardian Name (Print): ____________________

Parent/Guardian 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. *NYSED 2-08 SHCSD Revision 6-13*

Sweet Home Central School District

of Amherst and Tonawanda

PARENT LETTER REGARDING DENTAL CERTIFCATE

HF-18a-r
6-09

Dear Parent or Guardian:

A new law was recently enacted that expands health screenings to include a dental health inspection of students in New York State. After September 1, 2008, a dental certificate also will be requested at the same years a physical examination is required for students in Pre-kindergarten, Kindergarten, and in Grades 2, 4, 7 and 10.

Please have your child's dentist complete the certificate on the reverse side of this page and return it to your child's school Health Office. The certificate will be filed in your child's Cumulative Health Record folder.

Thank you for your cooperation. Contact your child's School Nurse if you have any questions or need further information.

SWEET HOME CENTRAL SCHOOL DISTRICT HF 18a 9-08

Dental Health Certificate

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

Name of School:

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/Guardian Name____

Parent/Guardian 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.

Sweet Home Central School District
of Amherst and Tonawanda

INVENTORY OF HEALTH INFORMATION

HF- 3b
Rev. 06-01-11

Entry Date ___________ **Grade** ___________ **Teacher/Homeroom** ____________________

____ ☐ M ☐ Fe ________ ______/______/______
Student's Name [Last / First / Middle] Age Birth Date

________________________________ ________________________ ________________________
Health Care Provider [HCP] Name HCP Phone Hospital of Choice

________________________________ ________________________
Dentist Name Dentist Phone

HEALTH HISTORY Please check ☑and list dates where appropriate (month/year):

☐ Anemia ________	☐ Freq. Colds/sore throat ________	☐ Scarlet Fever ________
☐ Cerebral Palsy ________	☐ German Measles ________	☐ Seizure Disorder ________
☐ Chicken Pox ________	☐ Heart Disease ________	☐ Staring Spells ________
☐ Convulsions ________	☐ Measles ________	☐ Tuberculosis [TBC] ________
☐ Diabetes ________	☐ Mumps ________	☐ TBC Contact ________
☐ Eczema ________	☐ Nephritis ________	☐ Whooping Cough ________
☐ Fainting Spells ________	☐ Rheumatic Fever ________	☐ Other ________________

Vision ☐ Glasses ☐ Contacts If yes, for ☐ Far ☐ Near Last eye exam date ____________
☐ Vision problems ____

Hearing ☐ Hearing loss ☐ Tubes in ears: ☐ R. ☐ L. ☐ Both ☐ Repeated ear infections
☐ History of hearing problems ____

Speech ☐ Speech not understandable to others ______________________________
☐ Possible defect, please have speech pathologist evaluate

Allergies ☐ Student is allergic: ☐ Food ☐ Environment ☐ Medication
☐ List allergies ____
☐ Epinephrine injection needed for emergency treatment: ☐ EpiPen ☐ Twinject ☐ Other

Asthma ☐ Student has asthma Student Uses: ☐ Nebulizer ☐ Peak Flow Meter ☐ Spacer
☐ Episodes of wheezing or coughing after active play ☐ Frequent coughing day or night
☐ Any visits to Health Care Provider, Urgent Care or Emergency Room for difficulty breathing

Medication ☐ Student receives medication ☐ Home ☐ School ☐ Asthma ☐ Other Medical Condition
State Condition and how often medicine is to be taken ______________________________
____

Food/Cultural Restrictions, e.g. milk intolerance, pork ______________________________
Other: Please state medical information that school health staff should know: (birth defects, operations, accidents, serious illness, injuries/fractures, nutritional modifications, etc.):
____
____

*** * COMPLETE THE AREA BELOW FOR KINDERGARTEN ONLY * ***

Developmental History Check ☑ below and give age in month & year where appropriate.
Pregnancy full term? ☐ Yes ☐ No Length of pregnancy ____________ Birth weight __________
Age began using single words ______ Age began using simple sentences ______ Walked ______

Other State any concerns that should be evaluated or discussed with you.
____
____

SWEET HOME CENTRAL SCHOOL DISTRICT
PARENT PERMISSION FOR PHYSICAL EXAMINATION

Dear Parent/Guardian:

Physical examinations are required by the Sweet Home Central School District according to the New York State School Health Law (Section 903). The following students are required to have a physical examination:

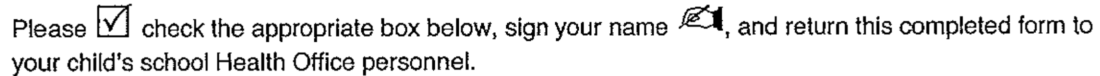
- ✓ All new entrants to the district, regardless of grade level.
- ✓ Students in Grades Pre-K, K, 2, 4, 7, 10.
- ✓ Special Education students are required to have a physical examination complete with a neurological screening upon initial placement and every three years as needed.
- ✓ Sports and working permits.

A Health Appraisal Form is available if the examination is to be given by your Primary Health Care Provider. This form should be **submitted within 30 days after the student's entrance** and is valid for one year through the last day of the month of the date on the health certificate with the exception of any illness or injury lasting more than five days that will negate the exam.

Please inform us if your child has had an exam, or if an appointment is scheduled with your Health Care Provider for a physical examination at the beginning of the school year by completing and returning this form.

Note: If a required health certificate is not submitted, a notice will be sent to you stating that if a health certificate is not furnished within 30 days from the date of the notice, a school physician or nurse practitioner will make an examination of the student.

You may contact the health office personnel if you have any questions or concerns. Thank you.



Please ☑ check the appropriate box below, sign your name ✍, and return this completed form to your child's school Health Office personnel.

☐ I have already submitted an examination form from my child's Health Care Provider.
Exam was given on (date) ________________ by (name) ______________________.

☐ My child is scheduled for a physical examination by our Health Care Provider on
(date) ________________ by (name) ______________________________________.
I will return the completed physical examination health form as soon as possible.

☐ My child may receive a school physical examination by the School Nurse Practitioner and/or School Physician.

______________________________ ______________________________
Student Name [please print] Grade/Teacher/HR

____
Parent/Guardian Name [please print]

______________________________ ______________
Parent/Guardian Signature Date