MASSENA CENTRAL SCHOOLS STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider)

Note: Please note: if your child is in grades Pre-K, K, 2, 4, 7, 10 or newly enrolled they are required to receive a health appraisal. We also request those student send in a Dental Health Certificate completed by his/her dentist. If you choose to have your child's NYS required health appraisal completed by his/her Medical Provider, see attached form and it must be to school within 30 days from the start of school. Sports Physicals must be completed by the school's Medical Provider. Vision, Hearing, and Scoliosis screenings are also completed by the school nurse according to NYS requirements. Please note only abnormal findings will be reported home.

NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name: _____ DOB: _____ Gender: ☐M ☐F

School: _____ Grade: ☐N/A Exam Date: _____

IMMUNIZATIONS
Please attach current immunization record

HEALTH HISTORY

☐**Asthma**: ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes**: ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures**: Type: _____ Last Occurrence: _____ ☐Emergency Care Plan Attached

☐**Allergies**: ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other: _____

Allergen(s): _____

☐Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:		Positive	Negative	Not Done	Date
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐ One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer: _____

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th- 94th

☐ 5th- 49th ☐ 95th- 98th

☐ 50th-84th ☐ 99th & higher

Vision	Right	Left	Referral
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes☐No

General Appearance _____

EENT _____ Neurological _____

Cardiovascular _____ Pulmonary _____

Abdomen/Hernias _____ Genitourinary _____

Spine/musculoskeletal _____

Additional Information _____

☐ Physical Exam Entirely normal

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☑ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** (please base restrictions/modifications on the following Interscholastic Sports Category

- ☐ **No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
- ☐ **Other Specific Restrictions:**

☐ Accommodations:	☐Protective Equipment	☐Sport Safety Goggles	☐Pacemaker
	☐Medical/Prosthetic Device	☐Athletic Cup	☐Insulin Pump/Insulin Sensor
	☐Brace/Orthotic	☐Hearing Aides	☐Other:

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____ _____

_____ _____

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: _____

Provider Address: _____ Fax #: _____

Return to:

School Nurse: _____ School: _____

Phone #: ( ) Fax: ( ) Date: _____

*Please note if you would like your child to receive any medications, including over the counter and prescription, he or she will require written order from their medical provider and written parent/guardian permission. The ordered medication will need to be brought to school by an adult in its original container. Any leftover medication must be picked up by an adult at the end of the school year. Massena Central School District will no longer provide stock medication at school. This is in accordance with NYS law and NYS recommended guidelines for Medication Administration at school.

MASSENA CENTRAL SCHOOL MEDICAL UPDATE

SCHOOL YEAR:_____

Please note: if your child is in grades Pre-K, K, 2, 4, 7, 10 or newly enrolled they are required to receive a health appraisal. We also request those student send in a Dental Health Certificate completed by his/her dentist. If you choose to have your child's NYS required health appraisal completed by his/her Medical Provider, see attached form and it must be to school within 30 days from the start of school. Sports Physicals must be completed by the school's Medical Provider. Vision, Hearing, and Scoliosis screenings are also completed by the school nurse according to NYS requirements. Please note only abnormal findings will be reported home.

STUDENT NAME_____ **DATE**_____

DOB_____ **AGE**_____ **MALE/FEMALE** (Circle One)

GRADE_____ **HOMEROOM** (NUMBER AND TEACHER)_____

DIABETES: YES NO **SEIZURE: YES NO** **ASTHMA: YES NO**

OTHER MEDICAL DIAGNOSIS_____

PLEASE EXPLAIN TREATMENT/MEDICATIONS: _____

_____

_____

_____

PLEASE CIRCLE ALL ALLERGIES THAT APPLY: BEE STING PEANUT OTHER NUT ALLERGY MEDICATION/DRUG

OTHER ALLERGIES_____

PLEASE EXPLAIN TREATMENT/MEDICATIONS (INCLUDING ORAL MEDICATION AND EPIPEN): _____

_____

_____

SINCE LAST SCHOOL YEAR HAS YOUR CHILD BEEN INJURED OR HAD AN ILLNESS THAT REQUIRED MEDICAL ATTENTION? YES NO (Circle One)

IF YES PLEASE EXPLAIN:

_____

_____

_____

IF YOUR CHILD REQUIRES DAILY/REGULAR MEDICATION PLEASE LIST AND EXPLAIN:

_____

_____

_____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

***Please note if you would like your child to receive any medications, including over the counter and prescription, he or she will require written order from their medical provider and written parent/guardian permission. The ordered medication will need to be brought to school by an adult in its original container. Any leftover medication must be picked up by an adult at the end of the school year. Massena Central School District will no longer provide stock medication at school. This is in accordance with NYS law and NYS recommended guidelines for Medication Administration at school.**

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 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.

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 oral health assessment ? ☐ Yes ☐ No

School: Massena Central School District 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/ Dental Hygienist

I. The dental health condition of _____ on_____ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist'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):_____

II. 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.

HEALTH RECORD

Student's Name: _____ Date of Birth: _____

Doctor's Name: _____ Phone #: _____

Has the student had any of the following? If yes, what year?

_____ Asthma	_____ Chicken Pox	_____ Diabetes
_____ Scarlet Fever	_____ Pneumonia	_____ Running Ears
_____ Measles	_____ German Measles (3day)	_____ Frequent Colds
_____ Tuberculosis	_____ Tuberculosis (immediate family)	_____ Kidney Disease
_____ Mumps	_____ Frequent Headaches	_____ Tonsillectomy
_____ Cerebral Palsy	_____ Epilepsy (type)	_____ Infantile Paralysis
_____ Rheumatic Fever	_____ Infectious Mononucleosis	_____ Learning Difficulties
_____ Infectious Hepatitis	_____ Speech/Language Difficulties	_____ Vision Problems
_____ Hearing Problems	_____ Special Diet	

_____ Allergies: _____

_____ Operations (state type & date): _____

_____ Serious Injury: _____

_____ Heart Disease (state type) congenital, murmur,etc: _____

Is student currently on any type of LONG TERM MEDICATION? If yes, please list the medical condition, type of medication, amount of dosage:

Condition: _____

Medication: _____ Dosage: _____

MASSENA CENTRAL SCHOOL DISTRICT SPECIAL NEEDS FORM
DIET PRESCRIPTION FOR MEALS AT SCHOOL

Name of student for whom special foods at school are requested: _____

Disability or medical condition that requires the student to have a special diet. Include brief description of the major life activity affected by the student's disability.

_____

_____

Is this condition permanent or temporary? _____
If temporary, please give length of time instructions are to be followed with explanation:

_____

_____

Diet Prescription: (Check all that apply)

__ Diabetic (Describe) _____
__ Reduced Calorie (Describe) _____
__ Increased Calorie (Describe) _____
__ Modified Texture (Describe) _____
__ Allergies (Describe) _____
__ Other (Describe) _____

_____

Foods Omitted and Substitutions: _____

_____ Meat and Meat Alternate (nuts, beans) may substitute with: _____

_____ Bread and Cereal (grains) may substitute with: _____

_____ Milk and Milk Products (includes ice cream) may substitute with: _____

_____ Fruit and Vegetables may substitute with: _____

Other Information Regarding Diet or Feeding: (Please provide additional information on the back of this form or attach to this form.)

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____

Physician's Signature Office Phone Number Date

_____

Print Physician's Name

_____

Address