



# Huntington Union Free School District

Office of Special Education & Student | Diana Rich, Director

Support Services

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May 2022

Dear Parents/Guardians,

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> grade.**

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

Enclosed you will find a copy of the New York State Student Health Examination Form. **Please note: the Huntington UFSD can only accept this approved form.**

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K, 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup>, & 11<sup>th</sup> grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Nurse's Office of your child's school with the date.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it. Attached is a form for your use.

We suggest you make copies of the completed forms for your own records before sending them to your child's School Nurse's Office.

Sincerely,

*Diana Rich*

Diana Rich, Director

Department of Special Education & Student Support Services

**A Tradition of Excellence since 1657**



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Mayo de 2022

Estimados padres/tutores:

La ley del estado de Nueva York requiere un examen de salud para todos los estudiantes **entrando al distrito escolar por primavera vez y al comenzar los grados Pre-K o K, 1, 3, 5, 7, 9 y 11.**

Un médico licenciado, asistente médico licenciado o enfermera practicante licenciado debe completar el examen.

Adjunto se encuentra una copia del formulario del examen de salud de estudiante y del Estado de Nueva York. **Tenga en cuenta que: el Huntington UFSD solo puede aceptar este formulario aprobado.**

- Una copia del examen de salud se debe entregar a la escuela dentro de 30 días desde el primer día que comienza su hijo(a) las clases, y cuando su hijo(a) comienza los grados K, 1, 3, 5, 7, 9 y 11. Si no entrega una copia a la escuela dentro de 30 días, la escuela lo contactará.
- Si su hijo(a) tiene una cita para el examen durante este año escolar que sucederá después de los primeros 30 días, por favor, notifique la oficina de la enfermera de su escuela de la fecha de la cita.
- La comunicación entre el personal médico privado y el personal médico escolar es importante para el cuidado seguro y efectivo en la escuela. Su proveedor de servicios médicos no puede compartir ninguna información de salud con el personal médico escolar sin su permiso escrito. Por favor, hable con su proveedor de servicios médicos acerca de firmar el formulario de consentimiento para la escuela durante la cita del examen físico de su hijo(a).

Se pide al mismo tiempo un certificado dental lo cual declara que un dentista o higienista dental ha examinado su hijo(a). La escuela proveerá una lista de dentistas e higienistas dentales registrados quienes ofrecen servicios dentales gratuitos o a precio reducido si se lo pide. Se adjunta una copia del formulario de la salud dental.

Sugerimos que haga copias de los formularios completados para su casa antes de mandárselos a la oficina de la enfermera de la escuela de su hijo(a).

Atentamente,

*Diana Rich*

Diana Rich, Directora

Departamento de Educación Especial y Servicios de Apoyo Estudiantil

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR  
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

**Risk Factors for Diabetes or Pre-Diabetes:** Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI \_\_\_\_\_ kg/m<sup>2</sup>

**Percentile (Weight Status Category):**  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  No  Yes  Not Done      **Hypertension:**  No  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</b>
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g}/\text{dL}$				

**System Review and Abnormal Findings Listed Below**

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

Assessment/Abnormalities Noted/Recommendations: \_\_\_\_\_ Diagnoses/Problems (list) \_\_\_\_\_ ICD-10 Code\* \_\_\_\_\_

Additional Information Attached

\*Required only for students with an IEP receiving Medicaid

<b>Name:</b>				<b>DOB:</b>
<b>Vision &amp; Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, &amp; 11</b>				
<b>Vision (w/correction if prescribed)</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
Notes				
<b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes				
<b>Scoliosis</b> Screen Boys in grade 9, and Girls in grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>				
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> <b>Other Restrictions:</b>				
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.				
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____				
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain.    *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
<b>MEDICATIONS</b>				
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>				
<b>IMMUNIZATIONS</b>				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		
<b>HEALTH CARE PROVIDER</b>				
Medical Provider Signature:				
Provider Name: <i>(please print)</i>				
Provider Address:				
Phone:		Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>				

## Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<small>Month Day Year</small>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<p>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.</p> <p>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.</p>					
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.