CORPUS CHRISTI HOLY ROSARY SCHOOL

(PORT CHESTER PUBLIC SCHOOLS HEALTH CERTIFICATE/APPRAISAL FORM)

Name: _____ **Date of Birth**: _____

School: _____ **Gender:** ❑ **M** ❑ **F** **Grade**_____

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
❒ No immunizations given today – see attached
❒ Immunizations reported on NYSIIS

Sickle Cell Screen: ❒ Positive ❒Negative ❒ Not done Date: _____
PPD: ❒ Positive ❒Negative ❒ Not done Date: _____
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: _____
Asthma: ❒Intermittent ❒ Persistent
Diabetes: ❒Type 1 ❒ Type 2
Seizures: Type _____ ❒ Concussion: _____
❒ Hyperlipidemia ❒ Hypertension

Significant Medical/Surgical History: ❒ See attached _____

_____

Allergies: ❒ Non-life threatening ❒ **LIFE THREATENING** ❒ Food: _____ ❒ Insect: _____ ❒ Latex:_____
❒ Seasonal: _____ ❒ Other: _____ ❒ Medication: _____

PHYSICAL EXAM

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

Body Mass Index: ____ ____ . ____	Vision - without glasses/contact lenses	R	L	
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: _____

MEDICATIONS

Medications (list all): ❒ None ❒ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION (WHERE APPROPRIATE) / 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:** _____
❒ **Restrictions:** _____
❒ **Protective equipment required:** ❒Hearing Aid/s ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Insulin Pump/Pod/Sensor

Provider's Signature:_____ Phone: _____

Provider's Name/Address: _____ Fax:_____

Provider Stamp

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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: 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.

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TO BE COMPLETED BY PARENTS:

PUPIL HEALTH INFORMATION

STUDENT'S NAME _____ SEX: M___F___ GRADE _____

LAST FIRST MIDDLE

ADDRESS _____ TELEPHONE _____

DATE OF BIRTH _____ PLACE OF BIRTH_____

FATHER'S/GUARDIAN'S NAME _____ CELL # _____

MOTHER'S/GUARDIAN'S NAME _____ CELL # _____

EMERGENCY CONTACT NAME _____ CELL # _____

NAME OF STUDENT'S PHYSICIAN _____TELEPHONE # _____

PLEASE INDICATE BELOW (YES OR NO) ANY OF THE FOLLOWING HEALTH PROBLEMS.
IF YES, GIVE APPROXIMATE DATE.

ALLERGIES (PLEASE SPECIFY)	SERIOUS INJURIES
ASTHMA	SEIZURE DISORDER
DIABETES	SPEECH PROBLEM
CURRENT MEDICATION	SURGERY
FRACTURES	VISUAL LOSS
HEARING LOSS	OTHER
HEART CONDITION	

_____ MY SON/DAUGHTER IS ABLE TO PARTICIPATE IN ALL PHYSICAL EDUCATION AND CO-CURRICULAR ACTIVITIES.

_____ MY SON/DAUGHTER IS NOT ABLE TO PARTICIPATE IN ALL PHYSICAL EDUCATION AND CO-CURRICULAR ACTIVITIES DUE TO _____. I UNDERSTAND A MEDICAL CERTIFICATE WILL BE REQUIRED FROM MY PHYSICIAN OR HEALTH FACILITY REGARDING THIS PROBLEM.

DATE _____ PARENT'S SIGNATURE_____

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Provider and Parent Permission to Administer Medication At School/School Sponsored Events

To be completed by parent:

Student Name:_____ Date of Birth:_____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. I request staff intervention and support during an emergency. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____ _____

Parent/Guardian Signature Date Phone where we can reach you ___Check if cell

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

____Allergy and requires Epinephrine Auto-injector

____Asthma or respiratory condition and requires Inhaled respiratory Rescue Medication

____Diabetes and requires Insulin/Glucagon/Diabetes Supplies

_____ which requires rapid administration of _____

(State Diagnosis) (Medication Name)

Signature:_____ Date:_____

Health Care Provider Written Permission for Medication:

Diagnosis:_____

Medication:_____

Dose_____ Route_____ Time(s)_____

Recommendations_____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after prescribed time. Please advise if there is a time-specific concern regarding administration.

____Independent Carry and Use Attestation (Required for Independent Carry and Use)

NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box to request this option.

_____ _____

Name/Title of Prescriber (please print) Date

_____ _____

Prescriber's Signature Phone

_____

Fax

Doctor's Stamp

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Immunization Requirement for Students Entering <u>Kindergarten</u>

Dear Parent/Guardian,

New York State Law Section 2164 and Port Chester Union Free School District requires certain immunizations to enter kindergarten and attend school. Please check with your health care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below.

Required Immunizations for Kindergarten

- **Polio**
  3-4 doses
- **Hepatitis B**
  3 doses
- **Diphtheria/Tetanus/Pertussis**
  4-5 doses
- **Measles/Mumps/Rubella**
  2 doses for measles and mumps, 1 dose for rubella
- **Varicella** (Chickenpox)
  2 doses

Please send proof of immunization to the school nurse.

Stephanie Gerardi, RN
School Nurse

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Immunization Requirement for Students Entering 6th Grade

Dear Parent/Guardian,

New York State Law Section 2164 and Port Chester Union Free School District requires certain immunizations to enter 6th grade and attend school. Please check with your Health Care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below:

- **Varicella** (chickenpox)
  2 doses – a health care provider's signed medical record indicating the student had varicella disease is acceptable proof of immunity.

- **Polio**
  3-4 doses

- **Hepatitis B**
  3 doses

- **DTP/DTaP/Tdap**
  3 doses

- **Tdap**

- **MMR**
  2 doses

If you have questions or concerns about immunizations, please contact the school nurse.

Stephanie Gerardi, RN
School Nurse

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Immunization Requirement for Students Entering 7th Grade

Dear Parent/Guardian,

New York State Public Health Law section 2164 and Port Chester-Rye Union Free School District are requiring children entering or attending grade seven to receive meningococcal vaccine starting on September 1, 2016.

Please send proof of immunization to the school nurse.

Stephanie Gerardi, RN
School Nurse