

**WEST ISLIP PUBLIC SCHOOLS
HEALTH SERVICES DEPARTMENT**

To: Parent/Guardian:

The New York State Education Law requires that every student have a health examination upon entrance into school at any grade level, and for each student entering Kindergarten, Second, Fourth, Seventh and Tenth Grades.

The periodic health examination performed in the office of the physician of the family's choice is of great value. Health problems can be detected, with correction and treatment started early.

Therefore, you are urged to have your family physician complete the medical examination form. Such examination shall be acceptable if they are administered not more than twelve months prior to the commencement of the school year in which the examination is required. *IF IT IS NOT RETURNED WITHIN 15 DAYS AFTER YOUR CHILD ENTERS SCHOOL, A HEALTH EXAMINATION APPOINTMENT WILL BE SCHEDULED WITH THE SCHOOL PHYSICIAN.*

It is also recommended that your child visit the family dentist twice annually since school-age children have the highest incidence of dental decay. Please return a Family Dentist Report for your child to the school at your earliest convenience.

FAMILY DENTIST REPORT

DATE: _____

NAME: _____ GRADE: _____

UNDER TREATMENT: _____

TREATMENT COMPLETED: _____

REMARKS: _____

DENTIST'S SIGNATURE



WEST ISLIP PUBLIC SCHOOLS

School Health Services

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).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

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 | <i>Referral</i> |
| Weight Status Category (BMI Percentile): | Vision - with glasses/contact lenses | R | L | |
| <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th | Vision - Near Point | R | L | |
| <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher | Hearing <input type="checkbox"/> 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 listed on reverse of 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. 2/08