HEALTH SERVICES INFORMATION

PHYSICAL & DENTAL EXAMS: Physical examinations are required for students in grades Pre-K, kindergarten, 2nd, 4th and 7th grade, and any student new to Queen of Heaven School. Dental exams are required for the same grades.

PREVENTATIVE SCREENING: During the school year students are screened for possible difficulties in the following areas: Vision (New students & grades PreK, K, 1, 2, 3, 5, & 7); Hearing (New students & grades PreK, K, 1, 2, 3, 5, & 7); Postural Defects (Scoliosis for grades 5-8).

NOTIFICATION OF DEFECTS TO THE PARENTS: Parents are notified of failures on vision, hearing and scoliosis screening by a paper referral sent home with your child. This notification should be returned as soon as possible stating the action taken by the medical examiner. The Health Office Staff welcomes information relative to your child's health. We are willing to assist you in referrals for health care, health education & health insurance.

CONTINUOUS HEALTH RECORDS: Please assist us in keeping your child's health record up-to-date by notifying the health office of any new physical condition, treatments, or immunizations for your child.

NOTIFICATION: Parent's will be notified of serious injury or illness. Parents are responsible for the transportation of ill children to home. Emergency phone numbers and details will be obtained from the student's emergency information sheet. **PLEASE NOTIFY THE SCHOOL OF ANY CHANGES IN YOUR WORK OR HOME PHONE NUMBERS.** If the parents are unable to be reached, the emergency contact sheet should reflect who is allowed to pick your child up if we are unable to reach you. Please make sure that these adults as listed HAVE ACCESS TO A CAR AND ARE AVAILABLE DURING SCHOOL HOURS.

ATTENDANCE: Please encourage regular school attendance as each day adds a step in his/her total development. However, please keep your child home if he/she shows any suspicious symptoms such as: sore throat, rash, colds, persistent cough, fever (anything over 100 degrees), "weepy lesions" around the nose or mouth, inflamed eyes or symptoms of a contagious disease. Please call the school if your child is absent.

MEDICATION POLICY: If it is necessary for your child to take medication during school hours, New York State Law requires a written NOTE FROM THE PARENT, and a written NOTE FROM THE DOCTOR. The supply of medications must be brought to the Health Office BY AN ADULT IN THE PHARMACY CONTAINER. The law applies to all medications including INHALERS, PAIN MEDICATION, COUGH DROPS, AND ALL OVER THE COUNTER MEDICATION.

PHYSICAL EDUCATION PROGRAM: Please inform the school if your child is unable to participate in a full physical education program (gym and swim). New York State Law requires a DOCTOR'S WRITTEN STATEMENT if a child is to be excluded from gym for a length of time (i.e. over a week). A doctor's permission is required for re-entry into the physical education program after a serious illness, sutures, surgery, fractures or other injuries.

CARE FOR INJURIES: School authorities may provide emergency care for illness & injuries which occur while the student is in school. Treatment is limited to first aid only. Home injuries are the responsibility of the parents/guardians.

If you have any questions regarding the health or health care of your student, feel free to call your School Nurse.
Thank You

West Seneca Central School District

Student Health History

TO BE COMPLETED BY PARENTS

Name _____
(Last) (First) (Middle)

Date of Entry _____ Entering Grade _____ Birth date _____ Sex _____

Address _____
(Street) (Town) (Zip Code)

Fathers Name _____ Mothers Name _____

Student's Primary Doctor _____ Phone _____

Last school attended _____

Does your child	**Please circle answer**	**Comment as necessary**
1. Have allergies (insect/food/environment)?	Yes No	To what? _____
2. Receive allergy shots?	Yes No	
3. Have asthma?	Yes No	How are they treated? _____
		_____
4. Have frequent cold?	Yes No	
5. Have frequent sore throats/strep throat?	Yes No	
6. Have frequent stomach aches?	Yes No	Describe _____
7. Have ear problems/tubes/loss of hearing?	Yes No	Describe _____
8. Wear glasses or contact lenses?	Yes No	Date of last exam _____
9. Have an orthopedic/bone/joint problem?	Yes No	Describe _____
10. Have frequent headaches?	Yes No	
11. Have fainting spells?	Yes No	Describe _____
12. Have a seizure disorder/staring spells?	Yes No	Comment on reverse side
13. Have diabetes?	Yes No	Comment on reverse side
14. Have a heart condition?	Yes No	Describe _____
15. Have kidney or bladder problems?	Yes No	Describe _____
16. Have anemia or other blood disorder?	Yes No	Describe _____
17. Have any skin conditions?	Yes No	Describe _____
18. Have scoliosis?	Yes No	
19. Wear dental braces?	Yes No	

West Seneca Central School District

Student Health History

Has your child ever been hospitalized for tests, illness, surgery? Explain if yes _____

_____

_____

Has your child ever been treated for serious injuries or fractures? Explain if yes _____

_____

_____

Does anyone at home have a medical problem? Explain if yes _____

_____

Are there any special problems or conditions we should know about to better understand your child? Explain if yes _____

_____

Will it be necessary for your child to take medication in school? Explain _____

_____ **(See nurse for medication regulations).**

STUDENTS ENTERING UPK THROUGH 6TH GRADE
PLEASE COMPLETE THE FOLLOWING:

GROWTH AND DEVELOPMENT OF YOUR CHILD

Birth weight _____ Premature birth? Yes No
Age at which your child: Walked _____ Toilet trained _____

STUDENTS ENTERING 7TH THROUGH 12TH GRADE
PLEASE COMPLETE THE FOLLOWING:

Does your child know how to swim? Yes No

Does your child have any medical restrictions that would prevent full participation in a swim program? Yes No

Explain if yes _____

IF YOU WISH TO HAVE A CONFERENCE WITH THE SCHOOL NURSE, PLEASE CHECK HERE _____

Additional Comments:

NYSED requires an annual physical exam for new entrants, students in Grades K,2,4,7&10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

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

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

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: _____

Significant Medical/Surgical History: ☐ See attached _____

_____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension

☐ Other: _____

Does this child have a history of concussion? ☐ Yes ☐ No If yes, please give date(s) and details: _____

Does this child have a history of ☐ chest pain ☐ heart disease ☐ lung disease

Is there a family history of sudden death from heart disease at a young age? ☐ Yes ☐ No If yes, please specify _____

Allergies: ☐ **LIFE THREATENING** ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____

☐ Seasonal ☐ Medication: _____ _____

PHYSICAL EXAM

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

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):

☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th

☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
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 (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: _____

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. 5/17/12 mkb

West Seneca Central School District
Record Of State Mandated Immunizations

Student Name: _____ Date of Birth: _____

Address: _____

New York State Public Health Law, Section 2164 mandates that schools shall not permit a child to be admitted unless the parent provides the school with a certificate of immunizations.

The required immunizations are:

- Three doses of **Diphtheria Toxoid** (usually administered as DPT, DT, DTaP or TD)
- One dose of **Tdap** (Adacel or Boostrix) entering 6th grade **and** who are 11 years of age or older.
- Three doses of **Pertussis and Tetanus** for children born on or after January 1, 2005.
- Three doses of **Polio** vaccine.
- Three doses of **Hepatitis B** (K-12 students born on or after 1/1/93; preschool children born on or after 1/1/95.)
- Two doses of **Measles** vaccine, the first administered after 12 months of age and the second after 15 months of age. One dose for preschool children.
- One dose of **Mumps** vaccine administered after 12 months of age.
- One dose of **Rubella** vaccine administered after 12 months of age.
- Three doses of **Haemophilus Influenzae Type B** (**HIB**) conjugate vaccine or 1 HIB, if administered over 15 months of age. (Preschool children only)
- One dose of **Varicella** vaccine (all children born on or after 1/1/1998) enrolled in any school. Dose must be administered after 12 months of age.
- Four doses of **Pneumococcal** vaccine (Preschool children only). Born on or after 1/1/2008.

Immunizations: (Give full dates)

Diphtheria: _____ _____ _____

Tdap, Adacal or Boostrix: _____

Pertussis/Tetanus: _____ _____ _____

Polio: _____ _____ _____

Hepatitis B: _____ _____ _____

MMR: _____ _____ _____ _____

HIB: _____ _____ _____

Varicella: _____

Pneumococcal: _____ _____ _____ _____

Other (specify): _____ _____ _____ _____

_____
(Print or Type Healthcare Provider's Name)

_____ _____
(Healthcare Provider's Signature) (Date)

HS323-3/2012

WEST SENECA CENTRAL SCHOOL DISTRICT

Administrative Offices • 1397 Orchard Park Road • West Seneca, New York 14224-4098
Telephone: 716/677-3156 • Facsimile: 716/677-3159

Mark J. Crawford, Ed.D.
Superintendent of Schools

Brian S. Graham
Assistant Superintendent-Pupil Services

As of September 1, 2008, school districts are now required to request dental health certificates from their students in Pre-Kindergarten or Kindergarten and in Grades 2, 4, 7 and 10. Please call your school nurse if you have any questions.

DENTAL EXAMINATION RECORD

Student Name _____ Date of Birth _____

Parent Name _____

Date of Exam _____

NOTE CONDITIONS AS CHECKED

☐ Cavities

Home brushing care

☐ Good ☐ Needs improvement ☐ Urgently needs improvement

Occlusion or Bite Relation

☐ Normal ☐ Abnormal

☐ Prompt and urgent attention is advised

☐ Mouth in apparently good condition

SPECIAL NOTE: Even though your child's mouth condition may be good at this time, routine and regular examinations by your family dentist are advisable. See her/him before your child complains of pain. Be watchful! Keep sugar intake low!

_____ D.D.S. _____
Signature of Examining Dentist Date

HS334-10/08

West Seneca Central School District

Administrative Offices • 1397 Orchard Park Road • West Seneca, New York 14224-4098
Telephone: 716/677-3156 • Facsimile: 716/677-3159

Mark J. Crawford, Ed.D.
Superintendent of Schools

Brian S. Graham
Assistant Superintendent - Pupil Services

Dear Parent/Guardian,

New York State Guidelines for Administration of Medication in a School Setting

School nurses, principals and other school personnel are often asked to dispense internal medication to school children. Internal medication can only be dispensed under the following policy:

1. **A written request from the parent/guardian.**
2. **A written request from the physician, which indicates the frequency and the dosage of the prescribed medication.**
3. **The medication is to be brought in the prescribed-labeled bottle by an adult to the office.**

Please do not send aspirin, cold pills, cough drops, inhalers etc. to school with your child. The dangers of this practice are possible choking and consumption of medication by another student resulting in serious consequences.

As stated above, medication will only be dispensed under the described conditions and this will be strictly adhered to within the school setting.

Please keep a copy of this notice for your records and forward the attached form to the school nurse.

Sincerely,

Brian Graham
Assistant Superintendent

HS82b-4/06

---------- Please Detach and Return to School ----------

I, _____ , have received a copy of the
(Please Print Parent/Guardian Name)

New York State Guidelines for Administration of Medication in a School Setting.

Name of Student _____
(Please Print Name)

Teacher _____ Grade _____ Room _____

Signature of Parent/Guardian _____ Date _____