Niagara Falls City School District
Department of Health Services

Dear Parents/Guardians:

New York State Education Law, amended September 29, 2005, mandates that all students who are in the **2nd, 4th, 7th& 10th** grade, special education classes and new entrants including Pre-K or K must provide the school with a current physical examination. We encourage you to have your child's health care provider complete this examination. Please have him/her complete the attached **Physical Examination** form ***or provide us with a computerized copy of your child's physical. If your child is entering the District for the first time, all forms must be returned to Central Registration at 630 66th Street. If your child attended a Niagara Falls District school last year, the forms may be returned to your child's school health office prior to the date of your school's scheduled examinations.*** (For exact dates check with your school registered nurse after September 1).

*****New Meningococcal Immunization mandated ~** *please see attached sheet for details and grades.* **Make an appointment with your child's health care provider or Health Department for immunization. Please be sure to bring a copy of your child's immunization record to school nurse.**
Parents/Guardians: please sign the Physical Examination form so that the Niagara Falls City School District may obtain medical information from your child's health care provider pertaining to the information indicated on the Physical Examination if needed.

Any health care provider physical COMPLETED ON OR AFTER SEPTEMBER 1, 2016 will be accepted. If this form is completed and returned, or if you provide the school nurse with a computerized copy of a physical completed by your child's health care provider, your child **will not** participate in the school physicals. ***In accordance with New York State law, the District Family Nurse Practitioner will provide a physical for students who do not return a completed physical examination form. Upon parental request parents are welcome to accompany their child during the physical exam. To complete a thorough exam, the removal of some clothing is necessary.***

****New York State Education Law, Section 903**, was amended to read "Each Health Certificate (physical exam) shall also state the student's body mass index (BMI) and weight status category… each school and school district shall participate in surveys directed by the commissioner of health pursuant to the public health law in relation to student's BMI and weight status categories…" The Niagara Falls School District may be selected to report Student Weight Status Category information for the students in Pre-K, or K, and in grades 2, 4, 7 and 10. PARENTS OR GUARDIANS MAY NOTIFY THE SCHOOL NURSE IN YOUR CHILD'S SCHOOL IF YOU WISH TO HAVE YOUR STUDENT'S BMI AND WEIGHT STATUS CATEGORY EXCLUDED IN THIS ANONYMOUS SURVEY.

***NYS Education Law requires that as of September 1, 2008, we will be requesting a dental certificate for all students in grades 2, 4, 7 and 10, and new entrants including Pre-K or K. Enclosed is a certificate for you to take to your child's dentist and once it is completed, it should be returned to your child's School Registered Nurse

Also enclosed in this packet is an **"Authorization for Use or Disclosure of Protected Health Information"**. If your child has an ongoing and/or chronic illness it may be necessary for the school nurse to contact your child's Health Care Provider. Please complete this form and return it to your child's school health office.

Please fill out the attached **Health History,** ***and*** return it to your school registered nurse. The health history is a significant part of any physical examination. It is important for the school to have current information about your child's health so that learning may be at its best.

In order that the physical examinations completed by the District Nurse Practitioner be thorough and of real value to the student, it will be necessary for the student to remove some clothing. Modesty will be maintained. You may be present at the examination to confer with your School Registered Nurse or the District Nurse Practitioner. Please contact your child's school nurse if you would like to be present for your child's physical exam.

You will receive a notice if there is any physical problem with your child. If notified, be sure to take your child to your health care provider or dentist as soon as possible.

If you have any questions, please call 286-0787, or your school nurse.
Thank you for your cooperation

PLEASE NOTE: Physical examinations completed by the District Family Nurse Practitioners may also be used for all interscholastic sports for a full calendar year, till the end of the month in which the examination was completed. *The student must declare an interest in a sport at the time of the physical examination*. All sports physicals required for the Niagara Falls City Schools must be completed by the District Family Nurse Practitioners, no other Physical Examinations will be accepted for the purpose of sports. Physical Examinations completed by the District Family Nurse Practitioners can NOT be released for the purpose of outside activities such as summer camps or summer sports programs.

Sincerely,
Health Services

Attachments:
Health History Form F-8: To be completed and signed by the parent and returned to your child's school health office
Physical Examination Form F-16A: To be completed by your child's health care provider
Authorization for Use or Disclosure of Protected Health Information J-28: To be completed and signed by the parent and returned to your child's school health office.
Dental Health Certificate (F16d) **Green F-16 4/17**

4455 Porter Road, Niagara Falls, NY 14305
Phone: (716) 286-0787 Fax: (716) 286-0758

Niagara Falls City School District
Department of Health Services
HEALTH HISTORY FORM FOR STUDENTS

Student's name_____ School _____ Grade_____

Address_____ Home Phone_____

Date of Birth_____ Place of Birth_____ Sex M____ F_____

Mothers Name_____ Address_____ Phone_____
Mothers Place of Employment_____ Work Phone_____
Fathers Name_____ Address_____ Phone_____
Fathers Place of Employment_____ Work Phone_____
Physician_____ Dentist_____

Emergency: 1. Name_____ Phone_____
2. Name_____ Phone _____

Describe your child's current state of health (circle one) Excellent Good Fair Poor

Please check YES or NO for questions below so that our School Health Service may best serve your child.
Explain any yes answers in the space provided on the back of the form.

HAS YOUR CHILD EVER HAD:

SKIN	**yes**	**no**	**date**
Lesions	___	___	___
Rashes	___	___	___
EYE PROBLEMS			
Vision loss-Rt eye_____ Lt eye_____			
Amblyopia- Rt eye_____ Lt eye_____			
Glasses	___	___	___
Contact lenses	___	___	___
Hearing loss – Rt ear____ Lt ear____			
Ear tubes - Rt ear____ Lt ear____			
Infections	___	___	___
Frequent nose bleeds	___	___	___
Nose fracture/surgery	___	___	___
SORE THROAT			
Tonsillitis	___	___	___
Strep throat	___	___	___
Scarlet fever	___	___	___
Tonsils/adenoids removed	___	___	___
DENTAL PROBLEMS			
Braces	___	___	___
Capped teeth	___	___	___
Bridge/loss of teeth	___	___	___
CARDIOVASCULAR			
High Blood Pressure	___	___	___
Rheumatic fever	___	___	___
Heart Murmur	___	___	___
Heart Surgery	___	___	___
Cardiac Workup	___	___	___
LUNGS/RESPIRATORY			
Asthma	___	___	___
Allergies	___	___	___
Hives	___	___	___
Hayfever	___	___	___
Pneumonia	___	___	___
Bronchitis	___	___	___
Tuberculosis	___	___	___

GASTROINTESTINAL	**yes**	**no**	**date**
Jaundice	___	___	_____
Stomach Disorders	___	___	_____
Frequent Abdominal pain	___	___	_____
Ulcers	___	___	_____
MUSCULOSKELETAL	___	___	_____
Arthritis	___	___	_____
Joint pains	___	___	_____
Limb or back deformities	___	___	_____
Fracture (broken bone)	___	___	_____
Dislocation	___	___	_____
Scoliosis	___	___	____
Chronic sprains	___	___	_____
Recurrent injuries	___	___	_____
GENITOURINARY			
Hernia	___	___	_____
Bladder or kidney disorder	___	___	_____
Infections	___	___	_____
MALES: Testicles: injury/surgery	___	___	_____
FEMALES: Menstruation	___	___	_____
Date first began_____			
Last menstrual period_____			
NEUROLOGICAL			
Headaches	___	___	_____
Head injuries	___	___	_____
Concussions	___	___	_____
Convulsions	___	___	_____
Seizure Disorder	___	___	_____
Fainting/blackouts	___	___	_____
Paralysis/numbness	___	___	_____
Hyperactivity	___	___	_____
ENDOCRINE			
Diabetes	___	___	_____
Hypoglycemia	___	___	_____
Thyroid Condition	___	___	____
COMMUNICABLE DISEASES			
Measles	___	___	_____
Chicken Pox	___	___	_____
Mononucleosis	___	___	_____

HEMATOLOGY

Hepatitis A yes___ no___ date____ **Hepatitis B** yes___ no___ date___ **Hepatitis C** yes____ no_____ date____
Anemia yes___ no___ date____ Bleeding disorders yes___ no___ date____ Transfusions yes____ no_____ date_____
Sickle Cell Anemia yes___ no___ date____

PLEASE CONTINUE ON OTHER SIDE

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Niagara Falls City School District
Department of Health Services

PLEASE LIST ALL MEDICATIONS YOUR CHILD WILL NEED AT SCHOOL:
All medications have side effects and for your child's safety it is important for the School Nurse to have this information.

MEDICATION **DOSE** **TIMES**

_____
_____
_____
_____

PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES AT HOME:

_____
_____
_____

HAS YOUR SON/ DAUGHTER:
Ever been a patient in a hospital?
Explain_____
_____

Had any operations? Explain_____

Had any accidents? Explain_____

Is your son/daughter under a physician's care now? _____

Is he/she allergic to any medication? _____

Has he/she had any psychological testing? _____

EXPLAIN YES ANSWERS HERE:

_____
_____
_____
_____
_____

PLEASE ADD ANY ADDITIONAL PERTINENT FAMILY MEDICAL HISTORY:

_____
_____
_____

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

Please contact the Health Office if you have any questions or if we may be of any service to you and your family.

_____ _____ _____

SCHOOL NURSE SCHOOL TELEPHONE

4455 Porter Road, Niagara Falls, NY 14305
Phone: (716) 286-0787 Fax: (716) 286-0758

Niagara Falls City School District
Department of Health Services

PHYSICAL EXAMINATION

Name_____D O B_____School_____ Grade _____

***I hereby grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child's health care provider pertaining to the information indicated in this physical.**

_____ _____

Parent/Guardian Signature **Parent/guardian printed name**

IMMUNIZATIONS/HEALTH HISTORY

□ Immunization record attached **Sickle Cell Screen: □ Positive □ Negative □ Not done Date: _____**
□ No Immunization given today **PPD: □ Positive □ Negative □ Not done Date_____**
□ Immunizations given since last appraisal **Elevated Lead □ Yes □ No □ Note 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

Date of exam: _____Height:_____ Weight_____ Vision R_____ L_____ B.P._____ Pulse_____
Body Mass Index_____ BMI Percentile: __ < 5 % __5% - 49% ___50% - 84% __85% - 94% ___95%-98% __99% and higher

☐ **EXAM ENTIRELY NORMAL** **specify any abnormality (use reverse of form if needed):_____**

Scoliosis: ___Negative ___Positive

Menarche_____ LMP_____ Testes _____ Tanner Stage I II III IV V

*****PLEASE SPECIFY CURRENT DISEASES:*** ___Asthma ___ Diabetes: ___Type 1 ___Type 2

___Hyperlipidemia ___Hypertension

MEDICATIONS

Medication: ☐ **None** ☐ **Medication at home only** ☐ **Medication to be given at school**
Name: _____
Dosage/Time: _____
(List additional medications on reverse of form)
If AM dose is missed at home: _____

Self-Administer attestation:
I attest that this student has demonstrated to me that they can self-administer the medication(s) listed above safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications listed above or on reverse of this form if needed: Yes ☐ No ☐

PHYSICAL EDUCATION/ SPORTS/ PLAYGROUND /WORK QUALIFICATION /CSE CONSIDERATION

____ Free from contagions & physically qualified for all physical education, sports, and playground, work and school activities OR only as checked below:

____ Limited contact: baseball, basketball, softball, volleyball, diving
____ Strenuous/non-contact: cross country, track & field, swimming, tennis, indoor track
____ Non strenuous/non-contact: bowling, golf, cheerleading

____ 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: _____

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

F 16a rev. 3/16

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Niagara Falls City School District
Department of Health Services

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your healthcare provider will require this release of information form to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or your school nurse to avoid delays.

I, _____ authorize my child's healthcare provider(s) listed below to release my
(Print name of parent/guardian)
child's _____ medical records to the district's medical officers, school nurse, and physical (PT), occupational (OT), speech therapists (ST) and/or Transportation Office:

Name_____Phone_____Fax_____
Name_____Phone_____Fax_____
Name_____Phone_____Fax_____
Name_____Phone_____Fax_____

The healthcare provider may disclose the following protected health information: (Check all that apply)
□ Immunizations
□ Health Appraisals
□ Past/Current Medical conditions that may affect Attendance, School Programming, and/or PT, OT, ST needs
□ Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Check all that apply)
□ To develop care or therapy plans for routine and emergent school management
□ To design appropriate educational programs
□ To assess the impact of the medical condition(s) on school programming and/or attendance
□ To share school observations/concerns surrounding behavior
□ To assess a medical basis for modification of transportation and/or home tutoring
□ Medication delivery and/or therapy prescriptions for PT, OT, ST
□ At patient's request with no specified purpose
□ Other _____

Please select one:

□ This authorization is valid for the entire academic school year 20___ - 20___
□ This authorization shall expire on ____/____/____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date Signature of Patient (Over 18), Parent or Guardian Relationship Phone

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child.

J-28 4/13

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Niagara Falls City School District
Department of Health Services

DENTAL HEALTH CERTIFICATE

Parent/guardian: New York State Law (chapter 281) permits schools to **request** a dental examination 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 dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

SECTION 1. TO BE COMPLETED BY PARENT/GUARDIAN (Please Print)

Child's Name: **Last** **First** **Middle**

_____

Birth Date: _____/_____/_____ **Sex: __ Male** **Will this be your child's first visit to a dentist?**
Month Day Year **__Female** **___Yes** **___No**

School: _____ 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 Signature_____Date_____

SECTION 2. TO BE COMPLETED BY THE DENTIST

1. **The Dental Health condition of _____ on _____ (date of exam). The date of exam 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 school.

____No, the student listed above is not in a fit condition of dental health to permit his/her attendance at school.

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. This may include pain, swelling or infection related to clinical evidence of open cavities. **The designation of "not in fit condition" does not preclude the student from attending school.**

_____ _____
Dentist's Name and address (please print or stamp) Dentist's signature

Optional Sections – If you agree to release this information to your child's school, 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 1/2mm 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 cavitated lesion is also present.)

___Yes ___No **Dental Sealants Present**

Other Problems_____

III Treatment Needs: ___No obvious problem. Routine dental care recommended. Visit your dentist regularly.
___ May need dental care. Please schedule an appointment with your dentist as soon as possible
___ Immediate dental care required. Please schedule an appointment with your dentist F-16d

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