Niagara Falls City School District
Health Services

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, 1st, 3rd, 5th, 7th, 9th and 11th grade**. Any physical examination completed on or after September 6, 2021, will be accepted if signed by a New York State licensed physician, physician assistant or nurse practitioner, and on the approved NYSED Student Health Examination form your doctor will have this form electronically. **New York State Education Law, Section 903, was amended to read "Each Health Certificate shall also state 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…" The Niagara Falls School District may be selected to report student weight status category information. PARENTS OR GUARDIANS MAY NOTIFY THE SCHOOL NURSE IN YOUR CHILD'S SCHOOL IF YOU WISH TO HAVE YOUR CHILD'S BMI AND WEIGHT STATUS CATEGORY EXCLUDED IN THIS ANONYMOUS SURVEY.

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. *(See reverse for dental certificate)*

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 Pre-K or K, 1st ,3rd, 5th, 7th, 9th & 11th grades. If a copy is not given to the school within 30 days, the school will contact you. *Your child's provider will have a copy of the form required.* We can accept any exam form dated after ***September 6 ,2021***. You or your provider may return the completed form to the school health office by ***October 6, 2022***.

*****See attached NYS Immunization Requirements for School Entrance/Attendance to be sure you child is up to date with their vaccines. To avoid exclusion from school all vaccines must be completed within 14 days from the first day of school, so be sure to complete all required immunizations over the summer.

- *****If you are unable to obtain a physical exam from your child's health care provider (HCP) a health appraisal will be completed at school, by the District Medical Director/Nurse Practitioner. In order for the physical appraisal to 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 also be present at the examination by notifying your child's school nurse, **fill out the attached health history in full and address the corresponding option.**
- If your child has an appointment for an exam during this school year with their HCP that is after the first 30 days of school, **please fill out the attached health history in full and address the corresponding option.**
- 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 the attached consent form for the school at the time of your child's appointment for the examination.

  We suggest you make copies of the completed forms for your own records before sending them to the school health office, which can be used for sports and camps. The school district can NOT reissue forms from your provider. Forms may also be faxed to your child's school nurse.

Sincerely,

Dr. Jo Silvaroli Medical Director/Nurse Practitioner

This resource was created by the New York State Center for School Health and is located at www.schoolhealthny.com – Forms | Notifications – 6/22

Dental Health Certificate- Optional

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: / / 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.

NIAGARA FALLS SCHOOL DISTRICT STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Been tested positive, had Symptoms or Diagnosed with COVID 19	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	See back section to give details
Had an operation	☐	☐	See back section to give details
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____
_____

Student's Name _____ Date of Birth _____ School _____ Grade ____

Please use this section for additional information or concerns:

_____

_____

_____

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? _____

Has he/she had any psychological testing? _____

ADDITIONAL SPACE TO EXPLAIN YES ANSWERS HERE:

_____

_____

PLEASE ADD ANY ADDITIONAL PERTINENT FAMILY MEDICAL HISTORY:

_____

_____

Please be sure to check all that apply and sign below.

☐ My child had a health exam with his/her Provider on _____ and I have attached a copy.

☐ My child has an appointment to have a physical with his/her health care provider on _____.
My child's MD/NP/PA or I will return the attached form to the school nurse.

☐ **Schedule the district nurse practitioner to complete the exam for my child. (*In order for the physical appraisal to be thorough and of real value to the student, it will be necessary for the student to remove some clothing. Modesty will be maintained.***

I would like to be present for my child's physical exam YES _____ NO _____

- **If yes check the best day you can attend: Mon: __ Tues: __ Wed: __ Thurs: __ Fri: __ AM or PM**

☐ I need information on obtaining health insurance or finding a health care provider.

PARENT OR GUARDIAN SIGNATURE_____ DATE_____

Parent Phone Contact ( ) _____

1. _____ _____ _____
   Emergency Contact Name Phone Number Relationship to student

2. _____ _____ _____
   Emergency Contact Name Phone Number Relationship to student