Niagara Falls City School District
Health Services

Dear Parent(s) and Guardian(s):

We want to take this opportunity to remind you of important health requirements for the upcoming school year. Please review the information below and contact us if you have any questions.

☐ **Health Examinations (physicals):**

- New York State law requires a health examination* for all new entrants and students in grades Pre-K or K, 1, 3, 5, 7, 9 & 11;
- Every year for students in 7-12 grade participating in athletics (sports) *Must be completed by the District Nurse Practitioner/Medical Director Call 716-286-0788 for an appointment.*
- For working papers as needed; or
- When required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

***A dental exam form is also requested at the same time a grade-level health examination is required.*

☐ **Immunizations (shots/vaccines):**

- New York State law requires all students entering or attending (including remotely) any New York State school (public, nonpublic, and charter schools) must receive all doses of immunizations required for their grade level in order to attend school. The immunization requirements for each grade level are outlined on NYSDOH Immunization Requirements for School Entrance/Attendance Chart. Students who do not have the required immunizations may not attend school.
- A request for medical exemption to immunization must be completed on this form: Medical Exemption Statement for Children 0-18 Years of Age (ny.gov).

☐ **Prescribed & Over-The-Counter Medications**

If your child needs to take medications during the school day the school must have the following:

- A written healthcare provider order, (Attestation is also required for independent students)
- Written parent/guardian consent, ***See page 3 section B in this packet***.
- The medication must be brought to the school by an adult. The medications must be in their original labeled prescription or over-the-counter bottles/packaging. Any special supplies or equipment for the nurse to administer the medication must also be provided to the school.

Attached is the *New York State Required Health Examination Form* you must give to the healthcare provider doing the health examination. You will also find a copy of the Health history, Dental Certificate but the *NYSDOH Immunization Requirements for School Entrance/Attendance Chart is not published as of this mailing please notify your child's school nurse for a copy.*

If you have any questions please reach out to your school nurse at your child's school.

Sincerely,

Dr. Jo Silvaroli DNP, FNP Medical Director/Nurse Practitioner F16 3/23

New York State Immunization Requirements for School Entrance/Attendance

Children attending day care and pre-K through 12th grade in New York State must receive all required doses of vaccines on the recommended schedule in order to attend or remain in school. This is true unless they have a valid medical exemption to immunization. This includes all public, private, and religious schools. A medical exemption is allowed when a child has a medical condition that prevents them from receiving a vaccine. There are no nonmedical exemptions to school vaccine requirements in NYS.

The CDC's Advisory Committee on Immunization Practices (ACIP) establishes the recommended vaccine schedule and determines when vaccines are due.

Important school immunization information

Within 14 days of the first day of school or day care, parents must:

- Show proof of their child's up-to-date vaccinations, OR
- Provide a valid medical exemption from vaccination.

In order to attend or remain in school or day care, children who are unvaccinated or overdue must receive at least the first dose of all required vaccines within the first 14 days. They also must receive subsequent vaccines in the series within a 14-day period of when they are due to complete the immunization series.

Vaccines required for day care, pre-K, and school attendance

- Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP or Tdap)
- Hepatitis B vaccine
- Measles, Mumps and Rubella vaccine (MMR)
- Polio vaccine
- Varicella (Chickenpox) vaccine

Additional vaccines required for middle school and high school

- Tdap vaccine for Grades 6-12
- Meningococcal conjugate vaccine (MenACWY) for Grades 7-12
- Students in Grade 12 need an additional booster dose of MenACWY on or after their 16th birthday

Additional vaccines required for day care and pre-K

- Haemophilus influenzae type b conjugate vaccine (HiB)
- Pneumococcal Conjugate vaccine (PCV)

IMPORTANT THINGS TO REMEMBER

1. The Niagara County Health Department provides immunizations by appointment only. Please Call 278-1903 for an appointment.
2. Parents must show proof of the required Immunizations within the first 14 days of attendance in school or within the first 30 days if transferring from a school district outside of NYS.

Niagara Falls City School District
Health Services

Date of Birth_____ Place of Birth_____ Gender at birth M____ F_____

Mothers Name_____ Address_____ Phone_____
Mothers Place of Employment_____ Work Phone_____
Fathers Name_____ Address_____ Phone_____
Fathers Place of Employment_____ Work Phone_____
Emergency: 1. Name_____ Phone_____
2. Name_____ Phone _____
Describe your child's current state of health (circle one) Excellent Good Fair Poor

A. Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
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
Females Age Menstruation began _____
Date of last menstrual period _____

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

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

_____
_____

HAS YOUR SON/DAUGHTER:

Ever been a patient in a hospital? Yes ___ No ___ If yes Date _____ explain _____
Had any operations? Yes ___ No ___ If yes Date _____ explain _____
Had any accidents? Yes ___ No ___ If yes Date _____ explain _____
Is your son/daughter under a physician's care now? Yes ___ No ___ explain _____
Is he/she allergic to any medication? Yes ___ No ___
Has he/she participated in any psychological testing? Yes ___ No ___ If yes Date _____

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM

PLEASE ADD ANY ADDITIONAL PERTINENT FAMILY MEDICAL HISTORY: _____

_____

PLEASE LIST ANY ADDITIONAL CONCERNS: _____

_____

(ATTACH AN ADDITIONAL SHEET IF NECESSARY)

Parent/Guardian Signature **REQUIRED**_____ Date _____

B. ***PLEASE LIST & SIGN FOR ALL MEDICATIONS YOUR CHILD WILL NEED AT SCHOOL.***

MEDICATION DOSE TIMES

_____

_____

_____

I request that my child receive the medication as prescribed by our health care provider. THE NEW YORK STATE EDUCATION DEPARTMENT REQUIRES THAT ALL MEDICATION IS TO BE FURNISHED BY ME IN A PROPERLY LABELED ORIGINAL CONTAINER FROM THE PHARMACY AND MUST BE BROUGHT TO THE SCHOOL HEALTH OFFICE BY A PARENT OR GUARDIAN.
It is the policy of the School District of the City of Niagara Falls that these procedures must be followed or the school will not be responsible for the administration of the medication. I understand that the school nurse, will administer the medication.

I agree if my child's health care provided allows HIM/HER to self-carry the approved medication.

Yes _____ No _____ Parent Initials _____

If yes please see section C *for the nurse to obtain the medical orders for the above medication.* If no *medication at school skip this signature*

Signature (Parent or Guardian) _____ Date_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

C. ***This sections/signature is optional:***

In order to share protected health information with the school district, your healthcare provider may require the completion of the statement below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete and sign the information below to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below to release
(Print name of parent/guardian)

My child's _____ medical records to the district's medical inspector or school nurse.
(Child's Name)

Health Care Providers Name _____ Phone _____

Health Care Providers Name _____ Phone _____

Health Care Providers Name _____ Phone _____

The healthcare provider may disclose the following protected health information: (Check all that apply)

☐ Immunizations
☐ Health Appraisals (Physical Exam)
☐ Current Medications listed in section B above
☐ Other_____

Signature (Parent or Guardian) _____ Date_____

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM J-28 3/23

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ Allergies	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Asthma	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Seizures	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Diabetes	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	With Correction ☐Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.			Not Done
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	IMMUNIZATIONS
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Niagara Falls City School District
Health Services

DENTAL HEALTH CERTIFICATE (To Be Completed by Child's Dental Office)

Parent/guardian: New York State Law (chapter 281) permits schools to **request** a dental examination in the following grades: school entry, Pre-K or K, 1, 3, 5, 7, 9 & 11. 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: ____/____/____ Gender: __ Male __ Female School: _____ Grade_____

Will this be your child's first visit to a dentist? ___Yes ___No

Have you noticed any problem 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