Skaneateles Central School District

Nationally Recognized for Excellence
45 East Elizabeth Street
Skaneateles, New York 13152

Eric Knuth
Superintendent of Schools
(315) 291-2221

Christine DeMass
Assistant Superintendent for Business Operations
(315) 291-2268
Fax (315) 685-0347

Information from the School Nurse

Michelle Persse, RN
291-2355

Physical examination: All new students to the district are required to have a physical exam completed. This exam should be dated within the twelve-month period prior to the first day of school and completed by a **New York State licensed physician.** A report of the health exam should be provided to the school nurse by the first day of school for entering kindergarten and within 30 days of entrance for grade 1 and all new students. New York State law does not permit accepting out of state physical exams—they MUST be performed by a NYS licensed physician.
For your planning purposes students are required by the state of New York to have physicals completed in grades K, 1, 3, 5, 7, 9 and 11. Also, NYS requires that all physical exams are submitted to the health office on the NEW NYS exam format.

Dental Certificates: A law was recently enacted that expands the health screening to include the request of a dental certificate. This should be submitted at the same time as the physical.

Immunizations: All children entering kindergarten must be fully immunized as outlined by the State of New York before the first day of school. Proof of this must be presented to the school nurse **by the first day of school.** The required immunizations for school attendance are as follows:
DPT- 4 or more doses
Polio- 3 or more doses
MMR- 2 doses
(The first immunization **must** have been given on or after the child's first birthday)
Hepatitis B- 3 dose series
Varicella- 2 doses (this immunization also **must** have been given after the first birthday)
If your child is entering mid-year from another state please see the school nurse to be sure your child has met these requirements.

Hearing and Vision screening: The school nurse does this at school for every student in grades K and 1st.

Medication policy: Your child may receive medication during the school day as long as the medicine is brought to school by a parent along with a doctor's written and signed order. The medication is kept in the health office and given to the student by the nurse. **Students are not allowed to self medicate. This applies to over the counter medication as well as prescription.**

Attendance: If your child will be absent from school please call the health office at 291-2355 and leave a message. For safety reasons I will attempt to locate your child if I have not heard from you. Please follow up with a written excuse when your child returns to school.

Please feel free to call me at any time with health information regarding your child or questions you may have. Information regarding medical concerns, especially food or bee sting allergies are appreciated ASAP. Please call 315-291-2355, fax 315-291-2302 or email mpersse@skanschools.org

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Immunization Requirements for Students Entering Kindergarten in 2020

Dear Parent/Guardian, Date: 2020-2021 school year

New York State law Section 2164 requires certain immunizations (shots) to enter kindergarten and attend school. Please check with your health care provider as soon as possible to make sure that your child has all of the needed immunizations. They are listed in the chart below.

REQUIRED IMMUNIZATIONS FOR KINDERGARTEN

Immunization	Number of Doses
Polio	3-5
Hepatitis B	3
Diphtheria/Tetanus/Pertussis	4-5
Measles/Mumps/Rubella	2
Varicella(Chickenpox)	2

Please send proof of immunization to the school nurse BEFORE school begins in September.

Proof of immunization must be **any 1 of the 3** items listed below:

- An immunization certificate signed by your health care provider
- Immunization Registry report (NYSIIS or CIR from NYC) from your health care provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases
    - For varicella (chickenpox), a letter from your health care provider (MD, NP or PA) which states that your child had the disease is also acceptable

If you have any questions or concerns about immunizations, please contact the Waterman school nurse, Michelle Persse at 315-291-2355 or email mpersse@skanschools.org.

Immunization records can be mailed to: Waterman Elementary 55 East Street Skaneateles, NY 13152 or can also be faxed to 315-291-2302.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental	
Asthma ☐ No	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : _____	
Seizures ☐ No	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: _____	Date of last seizure: _____
Diabetes ☐ No	☐ Medication/Treatment Order Attached	☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐ Type 1 ☐ Type 2 ☐ HgbA1c results: _____	Date Drawn: _____

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: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Dental Health Certificate
Skaneateles Central Schools

Parent/Guardian: New York State law (Chapter 281) directs schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up dated within the 12 months prior to the start of 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 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 visit to a dentist? ☐ 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

Parent Signature

Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months prior to 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 name and address (please print or stamp)

Dentist'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):_____

III. 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.

CHILD'S NAME: _____ DATE OF BIRTH: _____

HEALTH RECORD

Family Physician: _____ Phone: _____

Pediatrician: _____ Phone: _____

_____ Allergies	_____ Headaches	_____ Pneumonia
_____ Asthma	_____ Heart Disease	_____ Rheumatic Fever
_____ Chicken Pox	_____ Hepatitis	_____ Rubella Disease
_____ Epilepsy	_____ Measles Disease	_____ Scarlet Fever
_____ Diabetes	_____ Mononucleosis	_____ Tuberculosis
_____ Ear Conditions	_____ Meningitis	_____ Tonsillectomy
_____ Fifth Disease	_____ Mumps Disease	_____ Other
_____ Glasses/Contact Lenses	_____ Poliomyelitis	_____

Serious injury or illness with dates: _____ Surgeries with dates: _____

Is the child on medication? _____ If so, condition: _____ Medication: _____

Is child allergic to bee stings? _____ Epipen use? _____

Does this child need any special devices required for treatment or daily living? (Hearing aid, braces, catheter, aspirator, etc.)

Does this child exhibit problems such as lack of energy, head banging or rocking, anxiety, convulsions, poor coordination, sleeping, feeding or diet problems, tantrums, fears, chronic stomach aches, other (specify)? If so, please briefly describe circumstances.

Please list any other significant factors in infancy (condition upon delivery, respiratory problems, diet problems, RH incompatibility, illnesses, etc.) concerning your child's health, similar family health problems, disability or other information that will be of help in your child's adjustment to school. If necessary, visit with the school nurse.

Please provide verification of immunizations.

Parent or Guardian's Signature: _____ Date: _____