Dear Prospective Student and Parent/Guardian:

Welcome to the Highland Central School District! We wish you success in your studies and life here.

It is our district policy for out of state students to provide proof of immunization prior to entrance. Students within state are granted a two week period after school starts to present proof of immunization. It is the parents' responsibility to provide these records, although, if requested, the school will assist in obtaining the records.

It is vitally important to your child’s health and safety that you complete the emergency contact form and the medical update and return them to the guidance office or at the enrollment session before the start of classes.

Students are required by Article 19 of State Education Law to furnish a report of a physical examination within the past year for entrance to school. For the 2021/2022 school year it should occur between 9/8/20 and 9/8/21. If the student has had such an examination, please forward a copy of it to the school. If the student needs a physical examination, the form on the reverse side of this letter may be used by your medical provider. Your student will receive an examination at school, if a report is not submitted to the school by 10/20/21.

Students who need to take medication at school, during sports or during school sponsored field trips, whether prescribed or over the counter, will need a note from their doctor and a note from a parent/legal guardian. A form has been attached for your convenience.

Kindly return the aforementioned forms to the health office in your child’s building: Highland Elementary 691-1064; Highland Middle 691-1094; Highland High 691-1053.

Thank you for your cooperation.
Dear Parent/Guardian:

The district’s School Health Services program supports your student’s academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings will be required or completed at school:

**Vision**
- Distance acuity for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7 and 11.
- Near vision acuity and color perception screening for all newly entering students.

**Hearing**
- Hearing screening for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7 and 11.

**Scoliosis**
- Scoliosis (spinal curvature) screening for all male students in Grades 9, female students in Grades 5 and 7.

**Health Appraisals**
- A physical examination including Body Mass Index and Weight Status Category Information is required for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7, 9 and 11.

**Dental Certificates**
- A dental certificate is requested for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7, 9 and 11.

Please call your child school’s Health Office if you have any questions or concerns.

Elementary School Nurse’s Office: (845)691-1065
Fax: 691-1064

Middle School Nurse’s Office: (845)691-1085
Fax: 691-1094

High School Nurse’s office: (845) 691-1025
Fax: 691-1053
## NYS SCHOOL HEALTH EXAMINATION FORM

**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:**
- **Grade:**
- **Exam Date:**

### HEALTH HISTORY

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes/No</th>
<th>Treatment Order Attached</th>
<th>Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergies</strong></td>
<td>□ No</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td>□ No</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td><strong>Seizures</strong></td>
<td>□ No</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>□ No</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**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/No:**
- **Hypertension:** □ No □ Yes

### PHYSICAL EXAMINATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Test</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P/D/PRN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sickle Cell Screen/PRN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lead Level Required</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **BP:**
- **Pulse:**
- **Respirations:**
- **Other:**

**System Review and Exam Entirely Normal**

- **Test Done:** □
- **Lead Elevated >10 µg/dL:**
- **One Functioning:** □
- **Concussion – Last Occurrence:**

### Assessment/Abnormalities Noted/Recommendations

- **Diagnoses/Problems (list):**
- **ICD-10 Code:**

**Additional Information Attached**

5/1/2018 Page 1 of 2
**Name:**

**SCREENINGS**

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision — Near Vision</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision — Color</td>
<td></td>
<td></td>
<td>Pass</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Right dB</td>
<td>Left dB</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Scoliosis Required for boys grade 9</td>
<td>Negative</td>
<td>Positive</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Deviation Degree:</td>
<td>Trunk Rotation Angle:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations:**

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

- [ ] Full Activity without restrictions including Physical Education and Athletics.
- [ ] Restrictions/Adaptations
  - [ ] No Contact Sports
  - [ ] No Non-Contact Sports
- [ ] 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
  - [ ] Insulin Pump/Insulin Sensor*
  - [ ] Protective Equipment
  - [ ] Colostomy Appliance*
  - [ ] Medical/Prosthetic Device*
  - [ ] Sport Safety Goggles
  - [ ] Hearing Aids
  - [ ] Pacemaker/Defibrillator*
  - [ ] 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)*
- Provider Address:
- Phone:
- Fax:

*Please Return This Form To Your Child’s School When Entirely Completed.*
HIGHLAND CENTRAL SCHOOL DISTRICT

Provider and Parent Permission to Administer Medication
at School/School Sponsored Events

To Be Completed By Parent

Student Name: ___________________________ DOB: ________________
Grade: _____ Teacher/HR: __________________ School: ________________

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

Parent/Guardian Signature ___________________________ Date ____________

Email ___________________________ Phone Where We Can Reach You □ Check if Cell

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis ________________________________________________

Medication ________________________________________________

Dose ___________________________ Route ___________________________ Time(s) ___________________________

Recommendations ________________________________________ ICD Code ________________

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

□ Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)

NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

Name/Title of Prescriber (Please Print) ___________________________ Date ____________

Prescriber’s Signature ___________________________ Phone ___________________________

Email ___________________________ Stamp ___________________________

Return to:
School Nurse: ___________________________ School: ___________________________
School Address: ___________________________
Phone: ( ) ___________________________ Fax: ( ) ___________________________ Email ___________________________
# 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, ask your dentist 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)

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>/</td>
<td>Month Day Year</td>
<td>Sex: ☐ Male ☐ Female</td>
</tr>
<tr>
<td>School: Name:</td>
<td></td>
<td></td>
<td>Grade</td>
</tr>
</tbody>
</table>

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

**I. The Dental Health condition of __________________ on __________ (date of exam) The date of the 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 him/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit him/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**

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**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 1/2 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):**

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**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.