Return to Health Office

BOARD OF COOPERATIVE EDUCATIONAL SERVICES OF NASSAU COUNTY 3/11
HEALTH AND ALLIED SERVICES

PHYSICAL EXAMINATION

STUDENT_____ BIRTH DATE_____ DATE OF EXAM _____

PHYSICAL EXAMINATION: Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school district and all children in grades K, 2, 4, 7 and 10 will be examined by the school physician if no report is received.
***An annual physical examination is required for participation in interscholastic sports. (*Both sides must be completed.)**

1. BP_____ Pulse _____
2. Height _____ Weight _____
   Body Mass Index:_____ _____ . _____
   Weight Status Category (BMI Percentile)
   ☐less than 5th ☐5th- 49th ☐ 50th- 84th
   ☐85th- 94th ☐95th- 98th ☐99thand higher
3. Urinalysis_____
4. Heart _____
5. Breasts _____
6. Lungs _____
7. Eyes R _____ L _____
   With Glasses R _____ L _____
8. Visual Diagnosis _____
9. Ears: Otoscopic _____
   Audiometric _____
   P.E. tubes Yes ____ No _____
10. Speech_____
11. Nose _____
12. Throat _____
13. Tonsils _____
14. Teeth and gums _____
15. Skin _____
16. Glands (cervical, thyroid, other) _____
17. Nervous system _____
18. Hernia _____
19. Genitourinary _____
20. Tanner I. II. III. IV. V.
21. Orthopedic: scoliosis: ☐ positive ☐ negative
    posture _____ feet _____
    structural defects_____
22. Abdomen _____

SURGERIES: _____

SIGNIFICANT ILLNESSES / INJURIES: _____

ALLERGIES: _____

ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM

Full Activity_____ Restriction_____ Recommendation_____

CURRENT MEDICATIONS (please list all medications and dosages):

_____

_____

IMMUNIZATIONS *(please fill in or attach record of immunization)*

DPT or DTaP_____/_____/_____ (3 required)
Td or DT Booster_____
Tdap _____
Polio (OPV or IPV) _____/_____/_____ (3 required)
PCV ____/____/____/_____

MMR_____/_____ (2 measles required for Kindergarten)
Varicella_____/_____
HIB ____/____/____/____
Hep B_____/_____/_____ (3 required)
Other_____

PROCEDURES / TESTS

TB Screening_____
Chest X-ray_____
Sickle Cell Test_____
Lead Test_____ (Required for Pre School)

_____ _____ _____
Signature of Examining Physician Date Print Name

Physician's Address & Phone #
(PLEASE STAMP)

2051(a)-CIT-411

- please note reverse side of form for any student who anticipates trying out for a sports team - (Interscholastic sports form) →

INTERSCHOLASTIC SPORTS HEALTH EXAMINATION

Please complete both sides for participation in interscholastic sports.

This certifies that _____ is physically qualified to participate in the following categories of competition during this school year **except** those crossed out below.

CONTACT / COLLISION	LIMITED CONTACT / IMPACT	STRENUOUS NON-CONTACT	NON-STRENUOUS / NON-CONTACT
Field Hockey	Baseball	Crew	Archery
Football	Basketball	Cross Country	Bowling
Ice Hockey	Cheerleading	Track & Field	Golf
Lacrosse	Diving	Swimming	Riflery
Soccer	Gymnastics	Tennis	
Wrestling	Handball		
	Skiing		
	Cross Country		
	Downhill		
	Softball		
	Volleyball		

Physician
Signature: _____ Date:_____
Family Physician

---------- Sport

The school physician has the final responsibility for the determination of a student's physical eligibility to participate in interscholastic sports. This is in compliance with the State Education Department Regulation 135.4 (7) (h).

This student is cleared for participation in interscholastic sports as indicated above.

Physician
Signature: _____ Date: _____
School Physician

This form is MANDATORY for any student who resides OUTSIDE of Nassau County. For Example - Brooklyn, Queens, N.Y.C

NYC Department of Education

Christopher McKay, *Director*
Bureau of Non-Public School Payables

STATEMENT OF PARENT IN SUPPORT OF HEALTH SERVICE CLAIM FOR A NEW YORK CITY RESIDENT CHILD

SCHOOL YEAR ENDING JUNE 30,	NOTE TO CLAIMING SCHOOL DISTRICT - PLEASE COMPLETE ALL INFORMATION. IT WILL HELP TO ENABLE US TO PROCESS YOUR CLAIM MORE EFFICIENTLY. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE TUITION UNIT AT (718)935-2938	DATE
X		X

CLAIMING SCHOOL DISTRICT INFORMATION	OFFICIAL DESIGNATION OR TITLE OF SCHOOL DISTRICT
SCHOOL DISTRICT FEDERAL TAX ID NUMBER 11-2136917	NASSAU BOCES

MAILING ADDRESS: NUMBER & STREET, CITY, STATE, ZIP CODE
71 CLINTON ROAD

GARDEN CITY, NEW YORK 11530

FORM PREPARED BY (OR CONTACT PERSON) PRINT NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)
LINDA REIDER MANCZ	(516) 396-2255

STUDENT INFORMATION	PRINT OR TYPE ALL INFORMATION EXCEPT SIGNATURES			GRADE
DATE OF BIRTH (MM/DD/YY)	STUDENT'S LAST NAME	FIRST NAME	INITIAL	X
X	X			

NAME AND ADDRESS OF NON-PUBLIC SCHOOL CHILD IS ATTENDING
X

PARENT/GUARDIAN STATEMENT — PRINT NAME OF PARENT/GUARDIAN BELOW

I, X, **Parent/Guardian**

of the student named above hereby affirm:

1. That I am a legal resident of New York City residing at:

X

PRINT HOME ADDRESS (NUMBER AND STREET, BOUROUGH, ZIP CODE - PO BOXES ARE NOT ACCEPTABLE)

and intend to reside at this address throughout the school year referred to above. In the event of a change of residence to a location outside of New York City, notice of such change will be furnished, in writing, to the Department of Education of the City of New York, Non-Resident Tuition Unit, 65 Court Street - Room 1503, Brooklyn, NY 11201.

2. That my child, named above, is on the register of the aforementioned school for the school year referred to above and was on the school's register as of October 1st of that year.

AFFIRMED:

SIGNATURE OF PARENT/GUARDIAN

NEW YORK CITY TELEPHONE NUMBER (INCLUDE AREA CODE)

Subscribed to me on _____
DATE

SIGNATURE AND TITLE OF NON-PUBLIC SCHOOL OFFICIAL

FOR NYC DOE USE ONLY — VERIFIED BY:

* Allergy INFORMATION *

Authorization for Emergency Treatment

Students Name _____

Grade _____

Date of Birth _____

Contacts:

Parents' name _____ Home Number _____

Mother's Work Number _____ Mother's Cell Number _____

Father's Work Number _____ Father's Cell Number _____

Physician:

Allergist Name _____ Phone _____

Pediatrician Name _____ Phone _____

Additional Emergency Contacts:

Name _____ Relationship to child _____

Phone _____ *Hatzolah* 718-387-1750

I. Allergic to

_____

II. What has your child's reaction been in the past?

_____

_____

_____

III. The attached **medication authorization form** must be filled out and signed by both parent and M.D. Please have your physician send any information that will be helpful to us.

IV. Other Information (Please include whether student has been taught not to eat foods containing allergen or **those he is unsure of,** how responsible she is and any other information which may help us _____

_____

_____

Signature of Parent

IF your child has no allergies, please fill in the student name and place a line vertically through the page and return

Dental Health Certificate- Optional

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)

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

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 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.