Elmira City School District

Administration Building
951 Hoffman Street
Elmira, NY 14905

Phone: (607) 735-3000
www.elmiracityschools.com

Date: _____ School: _____

Student: _____ Grade: _____

Dear Parent or Guardian,

Dental health is an important part of overall health. Dental problems can make it hard for children to concentrate in school, can lead to other health problems, and can cause embarrassment and self-esteem issues.

New York State requires a certificate of dental health for your son or daughter:

- When they first enter the school district – at PreK, Kindergarten, or at any other grade level
- In grades 1, 3, 5, 7, 9 and 11

On the back of this letter is a certificate for you to take to your child's dentist; once it is completed, please return it to the school nurse. Your dentist may document any examination done on or after Sept. 1, 20_____. The certificate will be filed in your child's Cumulative Health Record at school. Please call the school health office at _____ if you have questions or concerns.

School fax number: _____

Thank you for your help. We appreciate your willingness to ensure your child's overall good health. This can really help him/her to be successful in school!

(Also, please keep an eye out in the fall for information about dental services provided at school. Most insurance plans accepted.)

Sincerely,
Your School Nursing Staff

Dental Health Certificate

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.

ELMIRA CITY SCHOOL DISTRICT
Physical Exam Needed

Date _____ School _____

Student _____ DOB _____ Grade _____

Dear Parent/Guardian,

State law says all students who are new entrants to our district (usually in PreK or Kindergarten), or who are in grades 1, 3, 5, 7, 9 or 11 must have a physical exam on file with the school nurse. **At this time, we don't have one on file for your child.** Please keep in mind that the reason for this law is to make sure all students are healthy, so they can learn to the best of their ability.

Ways you can take care of this:

- If your child has had a physical on or after Sept. 1, 20_____, please send a copy of that physical to the school nurse by Oct. 1st. We can accept physicals done by a doctor (MD or DO), nurse practitioner, or physician assistant.
- If you want your own healthcare provider to do your child's physical, but haven't had it done yet, please schedule an appointment now, and call the school nurse to let her know the appointment date.
- After Oct. 1st, if we haven't received a copy of a physical or notification of an appointment date, the school nurse practitioner will do the required physical exam on your child at school. If you wish to discuss this physical with the school nurse or be present during the exam, please contact your school nurse at _____ (phone). During physical exams performed at school, just as at your healthcare provider's office, boys will be checked for the presence of both testicles, and for inguinal hernia. Girls' breasts and genitalia may be visually examined, for the purpose of maturity screening. You may want to discuss this with your child, so he/she will know what to expect.

To give your healthcare provider permission to release your child's physical to Elmira City School District, please complete and return to school nurse:

Provider's Name (print): _____ **Phone:** _____

Parent/Guardian Name (print): _____ **Relationship:** _____

Parent/Guardian Signature: _____ **Date:** _____
(permission to release medical record expires one year after date of signature)

Please remember that it is not enough to have your child's physical exam done – you must have a copy of the examiner's findings sent to the school nurse. School fax: _____

New York State allows parents to request an exemption from a school physical on grounds of sincere and genuine religious beliefs only.

Sincerely,

The School Nurse and School Principal

white – parent/guardian
revised 4/19

yellow – student health record
595.49

ELMIRA CITY SCHOOL DISTRICT
EMERGENCY AND ANNUAL HEALTH HISTORY INFORMATION

****Please complete information on reverse side of form and return to School Health Office****

Student Information

Student's Name:

Birthdate: **Grade:** **Current Homeroom:** **Home Phone:**

Mailing Address:

Residence Address:

Relationship and name of person with whom student resides:

Parent/Guardian Information

To Parent or Guardian: In case of an accident, sudden illness or emergency school closing, please provide the following information:

Name:	**Relationship:**
Work Phone #:	**Cell Phone #:**

Name:	**Relationship:**
Work Phone #:	**Cell Phone #:**

Emergency Contact Information

Emergency Contact

Name:	**Phone #:**

If you have any address or phone number changes, please contact the main office at your child's school.

**** IMPORTANT ****
PLEASE TURN THIS PAGE OVER AND COMPLETE OTHER SIDE

Family Medical History

Are there any family members who have the following?

Asthma _____ **Diabetes** _____ **High Cholesterol** _____ **High Blood Pressure** _____

Note to Parent: New York State law requires that new entrants and students in Grades 1, 3, 5, 7, 9 & 11 have a physical.
If the student does not present a record of a physical done within the past year by the family doctor by October 1st, he/she will be examined by the school nurse practitioner.

Do you plan to have an exam by your family physician: YES: _____ NO: _____ Date: _____

or, the school nurse practitioner: YES: _____ NO: _____

Health condition or conditions which may require special care: _____

_____

Allergies to medication: _____

Medication taken at home or school: _____

Has your child during the past year had an illness, injuries, operations or special medical care?

_____

I/We authorize the Elmira City School District to act as temporary guardian to obtain medical or surgical care necessary for _____ who is my son/daughter, in the event that I cannot be contacted."

I/We grant permission to hospital, hospital physician, family physician, pediatrician or whomever he may designate to care for this patient in _____ Hospital by Doctor _____

Our insurance company is: _____

Our insurance numbers: _____

Date: _____

Mother: _____

Father: _____

Guardian: _____

(Signature of Parents/Guardian)

Student's Name:

Birthdate:

2021-22 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses** **or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]		**Not applicable**	**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses** **or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses** **or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**	**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses** **or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

Elmira City School District

Administration Building
951 Hoffman St. Elmira, NY 14905
607-735-3000

HEALTH INFORMATION

Name of Student _____ Date of Birth _____ Grade _____

Parents are urged to provide for their child's complete physical, dental, ear, and eye exams before school entrance. Parents are required to provide proof of immunizations by State Law.

DISEASE	YES/NO	DATE	DISEASE	YES/NO	DATE	DISEASE	YES/NO	DATE
Asthma			Bee Sting Allergy			Hernia		
Diabetes			Severe Food Allergy			Serious Injuries		
Seizure Disorder			Dizziness w/Exercise			Knee or Ankle Injury		
Heart Disease			Allergies/Hay Fever			Fracture or dislocation		
Fainting Spells			Rheumatic Fever			Concussion		
Nosebleeds			Scarlet Fever			Headaches		
High Cholesterol			Pneumonia			Physical Handicap		
Spleen Injury			Anemia			Ear Problems		
Neck or Back Injury			Problem Birth			Hearing Loss		
Bladder/Kidney Problems			Operations			Eye Problems		
Single Kidney			Hospitalizations			Vision Problems		
Single Testicle			High Lead Level			Uncorrectable Vision Loss		
Heart Problems/Murmur			High Blood Pressure			Glasses or Contact Lenses		

HEALTH HISTORY – Please explain any "YES" answers below. Use back of page if extra space is needed.

_____

_____

_____

Family Doctor: _____ Address: _____ PH# _____

Has there ever been a sudden death of a family member under 50 years of age? Yes _____ No _____
Cause: _____

Has your child ever been evaluated at any clinic such as heart, speech, hearing, mental health, etc.?
Yes: __ No: __ Clinic Name and Address: _____

Is your child taking any medications? Yes:___No: ____Please list medications: _____

_____

Will your child be taking any medications at school? Yes:___ No: ___ If yes, please speak to school nurse.

Is your child allergic to medication? Yes:___ No: ___ If yes, please name._____

Parents Signature: _____ Date: _____

595.04

8/2016