

Newfane Central School District Student Emergency Information

Child's Full Name: _____
Date of Birth: _____ Place of Birth (City, State): _____

Legal Guardian #1's Name: _____ Relationship: _____
Guardian's Address: _____ Home Phone: _____
Guardian's Employer: _____ Work Phone: _____
Cell Phone: _____ Nearest Phone (if no home phone): _____
Email: _____

Legal Guardian #2's Name: _____ Relationship: _____
Guardian's Address: _____ Home Phone: _____
Guardian's Employer: _____ Work Phone: _____
Cell Phone: _____ Nearest Phone (if no home phone): _____
Email: _____

If natural parent is not legal guardian, please complete next section:

Father's Name: _____ Any restrictions on release to this person? _____
Mother's Name: _____ Any restrictions on release to this person? _____
Are there any custody issues, restricted release situations of which we should be aware?

Emergency Contacts (Adults to whom child may be released if legal guardian in not available)

Name #1: _____ Relationship: _____
Phone: Home: _____ Work: _____ Cell: _____
Name #2: _____ Relationship: _____
Phone: Home: _____ Work: _____ Cell: _____
Name #3: _____ Relationship: _____
Phone: Home: _____ Work: _____ Cell: _____

Child's Usual Source of Medical Care

Name: _____
Address: _____
Phone: _____
Last seen: _____

Child's Usual Source of Dental Care

Name: _____
Address: _____
Phone: _____
Last seen: _____

Specialists: _____

Child's Health Insurance

Name of Insurance Plan: _____ ID# _____
Subscriber's Name (on insurance card): _____

Parent/Legal Guardian Consent and Agreement for Emergencies

As parent/legal guardian, I give consent to have my child receive first aid by school staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above receive health information and to act on my behalf until I am available. I agree to review and update this information whenever a change occurs.

Date: _____ Parent/Legal Guardian's Signature: _____

Newfane Central School District Sharing of Confidential Information

To ensure the safety and well being of your child while in our care, it is sometimes necessary to share your child's confidential health information with the staff that has direct care and responsibility for your child. We have found that most children in the younger age groups we service are not yet ready emotionally or physically to be responsible for identifying the need for and seeking appropriate medical interventions without adult guidance.

We attempt to provide child specific health care plans based on medical directions from your child's health care provider and developed with you, the parents, so that each child's individual needs are met at their level of need. We begin this process at registration with a review of your child's health care risks and needs. Further information may be requested from you and/or your child's healthcare provider to assist us in the development of your child's care plan. Please be assured that information shared is on a need to know basis, and is considered to be privileged and confidential by all of our staff. Staff may include, but is not limited to, the principal, teachers, instructional associates, school nurses, therapy providers, tutors, cafeteria staff, office staff, and bus drivers and aides and substitutes for all of these positions.

You have the right to restrict the information being shared with the staff that may have contact with your child during the school day as well as to restrict which staff may have access to this information. By signing below, you are giving us permission to share pertinent health information as needed to ensure that each staff person who has direct contact and responsibility for the care of your child is able to identify and appropriately respond to any special health care needs of your child. You have the right to rescind this consent at any time during the school year.

I, _____, give consent for the school nurse to consult with my child's healthcare providers to develop a plan of care for my child and for release of pertinent information from my child _____'s health history and health care plan with staff of the Newfane Central School District and Ridge Road Express who will have direct responsibility for the safety and care of my child, on a need to know basis as determined by the school nurse, or limited to the following staff:

Parent's Signature/Date

Parent's Signature/Date



Newfane Central School District Developmental History

Pupil's Name _____ Sex _____ Birth Date _____
(Last) (First) (Middle)

Prenatal / Pregnancy: Mother's age _____ Length of pregnancy _____ weeks Prenatal Care _____
Adopted _____ At what age _____ Foster Care _____ At what age _____

Pre-existing maternal medical conditions, medications used during pregnancy (prescription, over the counter and recreational), accidents or injuries during pregnancy, lack of or late prenatal care. Problems: infections, bleeding, high blood pressure, anemia, gestational diabetes, fever, trauma, inherited disease, medication (other than iron, vitamins), chronic disease, hospitalization, swelling, other: _____

Labor and Delivery: Length of labor _____
Type of delivery: Vaginal _____ Cesarean _____ Forceps _____ Suction _____ Breech _____

Anesthesia / Medications: _____

Neonatal: Birth weight _____ Premature _____ Postmature _____

Problems at birth or shortly after (breathing, infection, jaundice, bleeding, transfusions, antibiotics, birth defects, feeding, self temperature regulation, oxygen needs, blue spells, seizures, other): _____

Developmental: At what age did your child do the following: Sit alone _____ Roll over Unassisted _____

Stand alone _____ Walk alone _____ Sleep through the night _____

Speech: Words: _____ Sentences: _____ Toilet trained: Urine _____ Stool _____

Toileting assistance needed? _____ What type? _____ Frequent accidents? Fecal _____ Urine _____

Diapers/Pull ups currently used? _____ When: _____

Feeding habits: Regular mealtimes? _____ Snacks? _____ Over or Underweight for age? _____

Special diet needed? _____ Experience using utensils? _____

Usual tv/computer/video game usage: _____ Usual amount of daily physical activity: _____

Usual physical activities: _____ Organized activities? _____

Difficulty with: Tying shoes _____ Using zipper _____ Using buttons _____ Dressing self _____

Using scissors _____ Holding pencil/crayons _____ Mobility concerns _____

Usual bedtime _____ Usual # of hours of sleep _____ Naps: _____ Sleeps through night _____

Development: faster, slower, or equal to brothers/sisters/peers _____ Dominant hand: _____

Has your child ever been evaluated (other than well check-ups) for concerns with his/her:

Speech: _____ Fine or Gross Motor Abilities: _____ Behavior: _____ Vision: _____ Hearing: _____

Recommendations: _____

Please check the information that applies and add any pertinent information:

Allergies (specify reaction and allergen):

Foods _____

Environmental/Seasonal: _____

Insects: _____

Medications: _____

Accidents:

a. Serious head injury _____

b. Loss of consciousness _____

c. Other (specify) _____

Eye Difficulties:

a. "Lazy eye" _____

b. Glasses or contact lenses _____

c. Prosthesis _____

d. Other (specify) _____

Ear/Nose/Throat Problems:

a. Frequent ear infections _____

Age 0-2: _____ Current: _____

b. Tubes _____

c. Hearing loss _____

d. Throat infections _____

e. Enlarged tonsils or adenoids _____

f. Other (specify) _____

Heart Problems:

a. Heart murmur _____

b. Congenital heart disease _____

c. Rapid heartbeat/palpitations _____

d. Other (specify) _____

Respiratory Difficulties:

a. Asthma _____

Triggers: _____

b. Bronchitis/pneumonia _____

c. Cystic fibrosis _____

d. Other (specify) _____

Kidney/Bladder/Bowel Difficulties:

a. Kidney disease _____

b. Bladder infections _____

c. Urinary reflux _____

d. Enuresis (bedwetting) _____

Special Education Needs: _____

e. Chronic constipation _____

f. Encopresis (fecal soiling) _____

g. Undescended (or one) testicle(s) _____

Musculoskeletal/orthopedic problems:

a. Joint pain or swelling _____

b. Limitations of movement _____

c. Fractures _____

d. Braces/wheelchair/adaptive equipment _____

e. Prosthesis _____

f. Other (specify) _____

Poor Coordination (specify): _____

a. Fine or gross motor delays (specify) _____

Birth Defects (specify): _____

Hospitalizations / Operations (specify): _____

Illness with high fever (> 103°F): _____

a. Seizures _____

b. Staring spells _____

c. Tics _____

Currently or regularly taken medication _____

Reason _____

Is medication required in school? _____

Skin Conditions (specify): _____

Mononucleosis _____

Tuberculosis (TB) contact _____

Diabetes _____

Hepatitis _____

Thyroid disease _____

Gastric Reflux _____

Speech delay (specify): _____

Emotional problems (specify): _____

Attention problems (specify): _____

Elevated lead level: _____

Other (specify): _____

Does any close relative in your family have a history of: (Check and indicate relationship to this child.)

Diabetes _____

Cancer _____

High Blood Pressure _____

Birth Defect _____

Anemia _____

Epilepsy _____

Sickle Cell Anemia _____

Heart Disease _____

Learning Problems _____

Mental Retardation _____

Other _____

Have there been any changes or additions to the family in the past year? (health problems, changes in marital status/custody, changes in occupation, new brother or sister, etc.) Explain: _____

Signature _____

Parent/Guardian

Date: _____

NEWFANE CENTRAL SCHOOL DISTRICT HEALTH HISTORY

(To be completed by parent/guardian)

Student Name _____ Sex _____ Date of Birth ____/____/____
(Last, First, Middle Initial)

I. Life-Threatening Allergic Conditions: (Check all that apply.)

- Severe allergic reaction to Bee Stings, other insects: _____
- Severe reaction to Nuts, Peanuts: _____
- Severe reaction to other Food Products: _____
- Other severe allergies affecting school: _____

Please indicate any of your child's symptoms which would indicate a severe allergy: (Local swelling does *not* indicate a severe allergic reaction.)

- Itching and/or tightness in the throat, hoarseness Itching or swelling of the eyes, lips, tongue or mouth Hives
- Shortness of breath, coughing, and/or wheezing "Thready pulse", "passing out"/loss of consciousness

Has your physician prescribed an Epi-Pen or other medicine for a severe life threatening allergy? Yes* No

Specify medication: _____

* If you answered "Yes", it is strongly advised that he/she have this medication at school. Carefully read the **Medication Information** below.

II. Health Conditions: Has your child been diagnosed with any of the following? Provide dates and details for all items checked "Yes".

Yes	No	Condition	Details/Dates
		Allergies to medications	
		Allergies (environmental or seasonal)	
		Anemia	
		Asthma/Reactive Airway Uses an inhaler? ___ Yes ___ No Uses a nebulizer? ___ Yes ___ No If your child uses an inhaler or a nebulizer, it is strongly advised that he/she have this medication at school. Carefully read the <u>Medication Information</u> below.	
		Attention deficit: ___ ADD or ___ ADHD Date diagnosed _____ Meds: Yes No	
		Autism/PDD: ___ Autism or ___ Aspergers or ___ PDD-NOS (not otherwise specified)	
		Behavior problem	
		Bleeding disorder	
		Bowel or digestive problem	
		Cancer, Type: _____ Date diagnosed _____	
		Cerebral Palsy	
		Chromosomal disorder: ___ Down's syndrome ___ Other - specify -->	
		Cleft lip/palate	
		Cystic Fibrosis	
		Dental problem	
		Depression	
		Developmental Delay (learning, motor, speech) If yes, does your child receive special services? Yes No	
		Diabetes: Date diagnosed _____ Insulin Dependent: Yes No	
		Eating disorder: Anorexia Bulimia	
		Elevated lead level Date diagnosed _____ Last tested _____ Level _____	
		Emotional disorder	
		GERD Date diagnosed _____ Meds: Yes No	
		Growth problems	
		Heart problem: specify -->	
		Head Injury Type: _____	
		Hepatitis, Type: _____ Date diagnosed _____	
		Hernia Type: _____	
		High blood pressure	
		Hospitalizations: specify -->	
		Immunodeficiency disease	
		Kidney or urinary problem	
		Lyme Disease	
		Muscular disorder	

Yes	No	Condition	Details/Date
		Migraine headaches	
		Nutritional/weight problem	
		Orthopedic problem (bone, joint)	
		Pregnancy	
		Rheumatoid Arthritis	
		Scoliosis/abnormal spinal curve: Date of diagnosis _____ Date of last evaluation _____	
		Seizure disorder, Type _____ Date of last seizure: _____ Meds: <input type="checkbox"/> Yes <input type="checkbox"/> No. Medication _____ (Please provide physician documentation of diagnosis.)	
		Self Harm/Mutilation	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Substance abuse (alcohol, drugs, tobacco)	
		Suicide risk or attempt	
		Surgeries: specify →	
		Thyroid disorder	
		Tics or twitches	
		Tourette's syndrome	
		Tuberculosis	
		Other	

My child is healthy and has no special health needs.

Yes	No	HEARING	
		Hearing loss: [<input type="checkbox"/>] Right - <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe [<input type="checkbox"/>] Left - <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Hearing loss due to _____ Last evaluation _____
Yes	No	VISION	
		Color deficiency	
		Legally blind	
		Vision problem /Eye defect _____	Last eye exam _____
		Wears glasses [<input type="checkbox"/>] All the time [<input type="checkbox"/>] For distance only [<input type="checkbox"/>] For reading only [<input type="checkbox"/>] For sports	
		Wears contact lenses	

III. Medications: (Include all prescription, herbal and over-the-counter medication)

Name, dosage, route and frequency:	Used to Treat:

SCHOOL MEDICATION POLICY: If your child has a medical condition that requires medication in school, a written physician's order is required. No medication, including "over the counter" medications, may be carried by a student during regular school hours, at school-sponsored activities, such as field trips, and during after-school-hour activities. The only exceptions are for those students with asthma inhalers and Epi-Pens whose order specifies that they may "self administer" their medication and have been cleared by the school nurse. All medication must be delivered to the school Health Office by the parent/ guardian with the physician's original order and written parental permission. Medication order forms are available through the Health Office and on the District's website.

IV. Special Needs

Are there any other medical diagnoses or disabling conditions that might require a modification in your child's activities at school?
 Yes* No Specify: _____

*** Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation before modifications can be considered.**

I understand that if my child's health status changes during the school year, I will provide the Health Office with updated information.
 Parent/Guardian Signature _____ Date _____

NEWFANE CENTRAL SCHOOL DISTRICT

Education Law requires all students **enrolling** in the Newfane Central School District and all students entering **Pre-K or K** and in the **1st, 3rd, 5th, 7th, 9th and 11th** grades present a Certificate of Health, including BMI weight status, signed by a duly licensed health professional in NYS. The school will provide a basic physical examination if a Certificate of Health is not received or an appointment with your personal physician has not been scheduled by 30 days after entry of grades in which physical examination is required.

As the school's physical is limited to cardiovascular fitness and a general assessment of ears and throat, it is recommended that parents have their child examined annually by their family physician. If you choose to have your child/children examined by your own physician, please have your doctor complete the attached form and return it to me.

After September 1, 2008 when we require a physical exam, we will be requesting a dental certificate, as well. There is a sample certificate attached that you may take to your child's dentist and once it is completed, it should be returned to the school nurse to be filed in your child's Cumulative Health Record.

Please let us know your plans by completing the information requested below and returning this letter to me by October 1st.

Thank you for your cooperation in this matter.

Sincerely,

Your School Nurse

Newfane Early Childhood Center
Mrs. Teresa Trank, RN
Phone: (716) 778-6353
Fax: (716) 778-6364
ttrank@newfanecentralschools.org

Newfane Middle House
Mrs. Katie Betteridge, RN
Phone: (716) 778-6470
Fax: (716) 778-6362
kbetteridge@newfanecentralschools.org

Newfane Elementary School
Mrs. Donna Winans, RN
Phone: (716) 778-6374
Fax: (716) 778-6363
dwinans@newfanecentralschools.org

Newfane High School
Mrs. Lisa Erck, RN
Phone: (716) 778-6554
Fax: (176) 778-6361
lerck@newfanecentralschools.org

Our plan for providing the required Certificate of Health for: _____

Student's Name

_____ Have our family physician examine our child. Appointment set for _____ with Dr. _____.

_____ Certificate of health (physical examination) attached.

_____ Have the school physician examine our child.

_____ Requested dental appointment is set for ___/___/___ with Dr. _____

Parent or Guardian Signature

Date

2021-22 School Year New York State Immunization Requirements for School Entrance/Attendance¹

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

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
 - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
 - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 and 7: 10 years; minimum age for grades 8 through 12: 7 years)
 - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
 - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2021-2022, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 and 7; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 8 through 12.
 - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
 - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
 - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
 - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
 - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
 - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
 - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 and 8: 10 years; minimum age for grades 9 through 12: 6 weeks)
 - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
 - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
 - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
 - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
 - d. If dose 1 was received at 15 months or older, only 1 dose is required.
 - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
 - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
 - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
 - e. PCV is not required for children 5 years or older.
 - f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
 Bureau of Immunization
 Room 649, Corning Tower ESP
 Albany, NY 12237
 (518) 473-4437

New York City Department of Health and Mental Hygiene
 Program Support Unit, Bureau of Immunization,
 42-09 28th Street, 5th floor
 Long Island City, NY 11101
 (347) 396-2433

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5 \mu\text{g/dL}$				

System Review and Abnormal Findings Listed Below

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

Assessment/Abnormalities Noted/Recommendations: _____ Diagnoses/Problems (list) _____ ICD-10 Code* _____

Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name: _____ DOB: _____

SCREENINGS

Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes				
Hearing 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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes				
Scoliosis Screen: Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

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

- Student may participate in all activities without restrictions.
- 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 Age of First Menses (if applicable) : _____

Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

Order Form for Medication(s) Needed at School Attached

IMMUNIZATIONS

Record Attached Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:

Fax:

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

NEWFANE CENTRAL SCHOOL DISTRICT

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: / / / Sex: Male Will this be your child's first visit to a dentist? Yes No
Month Day Year Female

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 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 _____

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.

Newfane Early Childhood Center

Dental Resources

The following dentists accept Medicaid in addition to other commercial insurance plans.
***Federally Qualified Health Center Clinics must offer income based sliding fee scale.

Advantage Dental
1909 Pine Avenue
Niagara Falls, NY 14301
Phone: 282-4641
Fax: 282-0958

Aspire Family Dental
5875 S. Transit Road
Lockport, NY 14094
Phone: 280-1001
Fax: 439-1918
or
1705 Pine Avenue
Niagara Falls, NY 14301
Phone: 284-0110
Fax: 284-0046

Choice One Dental
2878 Niagara Falls Boulevard
Amherst, NY 14228
Phone: 693-2861
Fax: 693-7028

Eastern Niagara Dentistry
57 Davison Court, Suite D
Lockport, NY 14094
Phone: 433-6111

Gasport Community Dental Care
8403 Rochester Rd.
Gasport, NY 14067
Phone: 772-5590

Robert McLanahann, DDS
200 Ontario Street
Buffalo, NY 14207
Phone: 876-1233
Fax: 876-1234

Niagara Cerebral Palsy
9812 Lockport Road
Niagara Falls, NY 14304
Phone: 297-1478
(Geared to developmentally disabled population, services provided by Mario Violante, DDS)

NFMMC Dental Clinic***
501 Tenth Street
Niagara Falls, NY 14302
Phone: 285-2993
Fax: 285-8993
(Medicaid only)

Niagara Quality Care Dentistry
8875 Porter Road
Niagara Falls, NY 14304
Phone: 297-5500 / 297-1100
Fax: 297-5559

Marti Peterson DDS
Just 4 Me Pediatric and Adolescent Dental Care
1660 Hopkins Road
Getzville, NY 14068
Phone: 688-7721

Frank Pallone, DDS
552 Third Street
Niagara Falls, NY 14301
Phone: 284-8148
Fax: 284-8598

Peter Purcell, DDS
401 Potters Road
West Seneca, NY 14220
Phone: 822-2499
Fax: 821-9672

UB School of Dental Medicine
Department of Pediatrics
150 Squire Hall
Buffalo, NY 14214
Adults: 829-2732
Children: 829-2723
Orthodontics: 829-2845
Fax: 829-3895

University Pediatric Dentistry
521 Buffalo Avenue
Niagara Falls, NY 14303
(Children only)
Phone: 282-5725
Fax: 282-4557

or
1660 Hopkins Road – Suite 107
Getzville, NY 14068
Phone: 688-7712
Fax: 688-4719
or
107 Squire Hall (Main & Bailey)
Buffalo, NY 14214
Phone: 836-5595
Fax: 833-3517

Dale Voelker, DDS
1050 Oliver Street
North Tonawanda, NY 14120
Phone: 693-0600

Women & Children's Hospital of Buffalo – Dental Clinic***
219 Bryant Street
Buffalo, NY 14222
Phone: 878-7758
Fax: 888-3942

The following local family dentists do not accept Medicaid. Other insurances accepted; many have payment plan options.

Aesthetic Associates Centre
2500 Kensington Avenue
Amherst, NY 14226
Phone: 839-1700

Aesthetic Dental Care
210 Bewley Building
Lockport, NY 14094
Phone: 434-8720

Amherst Dentistry
8588 South Transit Road
East Amherst, NY 14051
Phone: 636-1399

Barzman, Kasimov & Vieth
2430 North Forest Road
Amherst, NY 14068
Phone: 636-8686

Genevieve Crofut, DDS
2715 Millersport Highway
Amherst, NY 14068
Phone: 688-4501

James Ferington, DDS
233 East Avenue
Lockport, NY 14094
Phone: 434-1900
Fax: 434-1975

Peter Igoe, DDS
511 West Avenue
Medina, NY 14103
Phone: (585) 798-4040

Igor Kaplansky, DDS
8038 Rochester Road
Gasport, NY 14067
Phone: 772-7500

Todd Levine, DDS
5875 South Transit Road
Lockport, NY 14094
Phone: 439-1877

Lockport Dental Group
39 Elizabeth Drive
Lockport, NY 14094
Phone: 434-6004

Lockport Family Dental Care
120 East Avenue
Lockport, NY 14094
Phone: 433-7222

Newfane Family Dentistry
2727 Main Street
Newfane, NY 14108
Phone: 778-7449

Drs. Potempa, Dick & Riad
219 Hawley Street
Lockport, NY 14094
Phone: 434-0610

or
261 Young Street
Wilson, NY 14172
Phone: 751-9773

Barry Ruchlin, DDS
(Children Only)
9386 Transit Road
East Amherst, NY 14051
Phone: 639-7301

Sharing Smiles Family Dental Care
3039 Lockport Olcott Road
Newfane, NY 14108
Phone: 778-5150

Suburban Family Dental
646 North French Road
Suite 8
West Amherst, NY
Phone: 691-3520

Lawrence Volland, DDS
115 Professional Parkway
Lockport, NY 14094
Phone: 434-5571

**NIAGARA COUNTY HEALTH DEPARTMENT
IMMUNIZATION PROGRAM SERVICES**

**** ALL CLINICS ARE BY APPOINTMENT ONLY ****

Hours: 9:00 – 11:30 am & 1:30 – 3:00 pm

Lockport

**Trinity Lutheran Church
67 Saxton at LaGrange St.**

Every 1st Friday (mornings)

Every 3rd Tuesday (mornings)

Niagara Falls

**Trott Access Building
1001 11th Street, 3rd floor**

Every 1st, 2nd and 4th Tuesday (full day)

**IMMUNIZATION CLINICS FOR CHILDREN
THROUGH 18 YEARS OF AGE:**

- Bring your child and the child's immunization records to each appointment
- Parent or Guardian must accompany children under age 18. If parent is unable to bring their child to clinic, a responsible adult over the age of 18 may be sent. They must be provided with the child's immunization record and a signed permission slip stating who is bringing their child to the clinic and granting permission for their child to receive the necessary vaccines.
- Vaccines are **free of charge** through age 18 for children qualifying for the Vaccines for Children Program (VFC). This also applies to individuals 19 years of age and older if they are attending college and requires the MMR vaccine. Vaccines are also available for a fee to children and adults with private insurance who are not eligible for VFC vaccine.

SERVICES OFFERED:

Recommended and required immunizations such as: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Varicella, HIB, Hepatitis B, Hepatitis A, HPV (girls & boys), Pneumococcal conjugate, Rotavirus, Typhoid, Meningococcal, Influenza and Rabies for pre-exposure for the disease.

Recommended and required immunizations for college students, if criteria are met.

Health & Insurance information provided, including Child Health Plus.

**FOR INFORMATION ABOUT IMMUNIZATION CLINICS,
ADULT, TRAVEL & FLU VACCINES – CALL 278-1903
PUBLIC HEALTH: PREVENT, PROMOTE. PROTECT.**