



Registration Health Office Check List

1. Current physical exam performed with the past calendar year.
2. Complete immunization record.
3. Completed health history form.
4. Lead level for entry to Pre-K.
(Can be indicated on the PE form)
5. Dental certificate.

New York State Immunization Requirements for School Entrance/Attendance¹

Vaccines	Pre-kindergarten (Day Care, Nursery, Head Start, or Pre-K) ²	School (K-12)
Diphtheria Toxoid-Containing Vaccine	3 doses (New York City Schools – 4 doses) ³	3 doses (New York City schools – 4 doses – required for kindergarten only)
Tetanus Toxoid-Containing Vaccine and Pertussis Vaccine (Tdap, DTaP)	3 doses if born on or after 1/1/2005	Not applicable until student born on or after 1/1/2005 enrolls in school
Tetanus, Diphtheria, and Pertussis Booster (Tdap)	Not applicable	Born on or after 1/1/94 and enrolling in grades 6 through 8 for the 2009-2010 school year ⁴ 1 dose
Polio (IPV or OPV)	3 doses	3 doses
Measles, Mumps and Rubella (MMR) ⁵	1 dose	2 doses of measles-containing vaccine and 1 dose each of mumps and rubella (preferably as MMR)
Hepatitis B	3 doses	3 doses ⁷
Haemophilus influenzae type b (Hib)	3 doses if less than 15 months of age or 1 dose administered on or after 15 months of age ⁸	Not applicable
Pneumococcal Conjugate Vaccine (PCV)	Born on or after 1/1/08 4 doses by 15 months of age, given at age-appropriate times and intervals ⁹	Not applicable
Varicella (Chickenpox) ¹⁰	Born on or after 1/1/2000	Born on or after 1/1/98 or born on or after 1/1/94 and enrolling in grades 6 through 10 for the 2009-2010 school year ¹⁰ 1 dose

**St. Augustine School
Health Services
Ossining Union Free School District**

Dear Parent/Guardian:

It is a fundamental policy of the Board of Education to have the medical examinations of pupils attending public schools made by the family's private physician, whenever possible. This policy recognizes the fact that the family physician is most familiar with the health problems of the pupil and best able to institute treatment when needed.

Our records show that many parents in this school district prefer to have their children examined by their family doctors. We are requesting these parents to have the form on the opposite side completed by the family doctor and returned to us as soon as possible. Summer examinations and camp physicals will meet the legal requirements for school examination.

If this examination is not returned, the school physician will do a health appraisal on all new students entering the school system and in **grades K, 2, 4, 7, and 10**. In the case of Special Education students, a physical is required at initial referral to the Committee and before triennial review.

Thank you for your cooperation.

Eric Small, M.D.
School Physician

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____
 School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal:
- Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

- Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____ Referral

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____
 Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 _____ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 _____ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
- Specify medical accommodations needed for school: _____ None
 Known or suspected disability: _____ Please monitor
 Restrictions: _____ Please monitor
 Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)
 Provider's Name/Address: _____ Fax: _____
 Parent Signature: _____ Date: _____

Pupil Health History Form
St. Augustine School
Ossining Union Free School District

Child's Name _____ Date of Birth _____ Phone _____
 Address _____
 Physician _____ Office Phone _____
 Dentist _____ Office Phone _____

If student has any of the following please indicate and supply dates:

CONDITION	Yes	No	Comments if "Yes"
Attention-Deficit/Hyperactivity Disorder			
Allergies (food, insects, drugs, latex)			
Allergies (seasonal)			
Asthma or breathing problems			
Behavioral problems			
Developmental problems			
Bladder problems			
Bleeding problems			
Bowel problem			
Cerebral Palsy			
Cystic Fibrosis			
Dental Problems			
Diabetes			
Head or spinal injury			
Hearing problems or deficit			
Heart problems			
Hospitalizations (when, why)			
Lead poisoning			
Muscular problems			
Seizures			
Sickle Cell Disease (not trait)			
Speech problems			
Surgery (when, why)			
Vision problems			
Other:			

Does your child take any medication on a daily or regular basis? If so what and when? _____

*If a medication needs to be administered at school a prescription from your doctor is required and a separate medicine container to be left at school.

Parent/Guardian Signature _____ Date _____ Relationship _____

St. Augustine School

Rt. 9 Eagle Park

Ossining, NY 10562

914-944-0826

DENTAL CERTIFICATE

To Parent or Guardian:

Children should be taken to the dentist when they are three years old or as soon as all the baby teeth are in place. They should be seen at regular six month intervals thereafter.

Decayed teeth are a source of danger to general health and interfere with progress and attendance in school. A periodic check-up, including x-ray, is therefore recommended to detect hidden decay.

PLEASE HAVE YOUR DENTIST SIGN THIS FORM AND RETURN IT TO THE SCHOOL.

Dental Examination of: _____
(Student name) (DOB)

Home Address: _____

Please check the appropriate statement and sign:

() Annual exam completed on: _____
(Date)

() I am currently treating this patient for: _____
(Condition)

Signed: _____
(Dentist)

Address: _____
