BRUNSWICK CENTRAL SCHOOLS
BRITTONKILL

HEALTH INFORMATION

Please be sure to fill out completely:

STUDENT INFORMATION:
Student's Name_____Birthdate_____Grade_____

Guardian #1 Name_____ **Guardian #2** Name_____

Address_____Home Phone_____

IMMUNIZATIONS:

It is required by law that student's immunization record must be supplied to the school on or before the first day of attendance. If you do not have records with you upon registration, please make arrangements with your child's doctor or previous school to either send or fax them to us. Our fax number is 279-1918, to the attention of the Health Office.

MEDICAL HISTORY:

Medicine above student is currently taking:

DRUG MILLIGRAMS REASON FOR TAKING MEDICATION

_____

Please check all that apply:

____Allergies (Please explain)_____

Medicines allergic to:_____

Is student allergic to insect stings? YES NO (circle one)

If YES to above question: What medicine should be taken for the sting _____

Please give time allowed before medicine must be given_____

Note: If possible, please see that the nurse has at least one of these pills in case an outside activity is scheduled.

____Frequent absenteeism (Please explain)_____

____Frequent colds/sore throats ____Ear conditions ____Chicken Pox

____Frequent headaches ____Asthma ____Pneumonia

____Epilepsy ____Diabetes ____Heart Disease

____Rheumatic Fever

____Has had Tuberculosis or contact with infected person

____Family History of color blindness? Who?_____

____Serious injuries/or illness (Please explain)_____

____Operations (Please explain) _____

____Other (Please explain)_____

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EMERGENCY INFORMATION:

Guardian #1 place of employment_____ Wk. Phone Number_____

Guardian #2 place of employment_____ Wk. Phone Number_____

Attempt will be made to contact parent(s) in case of emergency. If not able to contact a parent, who should be contacted?

Name Address Home Ph. Work Ph.:_____

Physician's Name Phone _____ _____

Should transportation be necessary, what hospital would you want your child to be taken to:_____

(Please read carefully)

In the event of any sudden illness or injury while involved in a school related activity, I give my permission for emergency treatment to be given by personnel who hold valid and up-dated first aid cards, and if necessary transportation to a hospital where the medical staff may also treat my child.

It is understood that I will be immediately contacted in the event of any emergency, but that treatment and transportation can be started in the interim. Should it be impossible to reach me I agree that treatment and transportation begin as stated.

Date_____ Parent or Guardian_____

Parent Authorization for Release of Medical Information

We, (I), the undersigned, who are the parent/guardian of

_____ _____

Name Date of Birth

give authorization to _____

Physician's Name

for release of medical information (for the duration of the child's school career) pertaining to, but not limited to, physicals, immunizations records, gym notes and medication permits to:

Brunswick (Brittonkill) Central School District
3992 NY 2
Troy, NY 12180

_____

Parent/Guardian Signature

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Parent/Guardian,

New York State law requires that any child entering a new school for the first time must have a physical. A copy of this physical must be on file in the health office. You have the option of either having your family physician perform the examination, or you can choose to have the school doctor do it during school hours.

If you plan on having your family physician do the exam, then please take these forms with you and have your doctor fill them out. Please send the forms back to school as soon as possible. If the health office does not receive these forms within two weeks of admittance, the school physician will automatically exam your child.

If you would rather the school physician perform the exam, then check below and submit the form with the rest of the registration paperwork.

_____ I would like the school doctor to examine my child.

_____ I DO **NOT** want my child to be examined at school

I will have my child examined and return the School Physical Exam Form within 30 days.

_____
Child's Name

_____ _____
Parent/Guardian Signature Date

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Dear Parent or Guardian:

As a part of your child's requirements for school, a physical examination has been required for students in Prekindergarten or Kindergarten and in Grades 2, 4, 7 and 10. A law was recently enacted that expands health screenings to include the dental health of students in New York State.

After September 1, 2008, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse as it will be filed in your child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the school's Health Office if you have any questions or concerns.

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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)

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.

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