

# Plainview Old Bethpage Central School District

106 Washington Avenue, Plainview, New York 11803



## *Parkway Elementary School*

DATE: April 1<sup>st</sup> 2009

Dear Parent/Guardian,

As part of the required school examination, your child is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or "BMI". The BMI helps the doctor or nurse to know if the student's weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require the BMI and weight status group be included as part of the student's school health examination. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting to New York State Department of Health information about our students' weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report.

The information sent to the New York State Department of Health will help health officials develop programs that make it easier for children to be healthier.

If you do not wish to have your child's weight status group information included as part of the Health Department's survey this year, please print and sign your name below and return this form to your school nurse.

Thank you very much for your cooperation.

Sylvia Seidel R.N.

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Please do not include my child's weight status information in the 2009-2010 School Survey.

\_\_\_\_\_  
Print Child's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent's Name

\_\_\_\_\_  
Parent's Signature



# PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT HEALTH EXAMINATION

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ Room: \_\_\_\_\_

**PHYSICIAN COMPLETE (\*Actual Readings)**

* Height:	* Blood Pressure:	* Pulse:
* Weight:	Abdomen:	
Eyes:	Hernia:	
Ears:	Heart:	
Vision: w/glasses _____ w/o glasses _____	Lungs:	
Nose & Throat:	Urinalysis: Sugar _____ Protein _____ Blood _____	
Mouth & Teeth:	Orthopedic: * Scoliosis	
Skin:	Allergies: _____ Seasonal _____ Life Threatening _____ Asthma _____ Medication	

<b>* BODY MASS INDEX*:</b>		
<b>WEIGHT STATUS CATEGORY (BMI) PERCENTILE:</b>		
_____ Less than 5%	_____ 5th through 49th%	_____ 50th through 84th%
_____ 85th through 94th%	_____ 95th through 98th%	_____ 99th and higher

**Specify current diseases:**  Asthma  Diabetes type 1  Diabetes type 2  Cholesterol  Hypertension

May student participate in physical education activities? \_\_\_\_\_

Recommendations for adjustment of school program: \_\_\_\_\_

Does student require medication?  Yes  No If yes, please specify: \_\_\_\_\_

Physician's Signature and Stamp: \_\_\_\_\_

Actual Date of Physical: \_\_\_\_\_

**IMMUNIZATIONS AND TESTS**

IMMUNIZATIONS	DATE-1 <sup>ST</sup> DOSE	DATE -2 <sup>ND</sup> DOSE	DATE-3 <sup>RD</sup> DOSE	DATE-1 <sup>ST</sup> BOOSTER	DATE-2 <sup>ND</sup> BOOSTER
Polio					
Dtap					
Tdap or TD					
MMR					
Measles					
Mumps					
Rubella					
Hib					
Hep B					
Hep A					
Varicella					
Pneumococcal					
PPD (Tuberculin)					
Meningococcal Vaccine					
Other					

**Legal Requirements for Immunization waived because of:** Religious Exemption \_\_\_\_\_ Medical Exemption \_\_\_\_\_



**TO BE COMPLETED BY PARENT OR GUARDIAN**

School Student is attending: \_\_\_\_\_

Teacher \_\_\_\_\_ Grade \_\_\_\_\_ Room #: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell/Work: (mother/guardian): \_\_\_\_\_ (father): \_\_\_\_\_

Address: \_\_\_\_\_

**YOUR CHILD MUST RETURN A PRIVATE PHYSICIAN'S EXAMINATION FORM BY OCTOBER 1st.  
OTHERWISE HE/SHE WILL HAVE A SCHOOL HEALTH APPRAISAL.**

1. Has your child, during the past year, had any illness, injury, or operation? If so, please specify, with dates:  
\_\_\_\_\_
2. Has your child received any immunization or tests during the past year? If so, please specify dates and type of immunization or tests not recorded on reverse side of form:  
\_\_\_\_\_
3. Is your child under medical supervision for allergies? If so, please specify type, symptoms and treatment:  
\_\_\_\_\_
4. Does your child take any medication on a regular basis? (*Self-Medication in school is illegal according to State Education Law.*) If your child must take any medication during the school hours, please consult with your school nurse regarding procedures:  
\_\_\_\_\_
5. Do you have any other information which would aid the school in a better understanding of your child?  
\_\_\_\_\_
6. Please list two neighbors who will be available to be called in case of illness or emergency:

NAME	RELATIONSHIP	ADDRESS	PHONE #
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NAME	RELATIONSHIP	ADDRESS	PHONE #
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**TO BE CALLED IN CASE OF EMERGENCY:**

7. Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**To the best of my knowledge, the above information is correct:**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT  
OFFICE OF THE SCHOOL NURSE

DENTAL HEALTH CERTIFICATE

STUDENT'S NAME \_\_\_\_\_  
SCHOOL \_\_\_\_\_ TEACHER \_\_\_\_\_

Dear Parent or Guardian:

New York State law (Chap. 281) instructs schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. We recommend that each student visit the dentist every six (6) months in order to maintain good dental health, however, we request only one dental form during the above school years. Please ask your dentist to complete this form and return it to your school nurse.

TO BE COMPLETED BY THE DENTIST

THIS IS TO CERTIFY THAT A DENTAL EXAMINATION IS COMPLETE AND TO INFORM YOU THAT:

(PLEASE CHECK ANY THAT APPLY)

NO TREATMENT IS NECESSARY AT THIS TIME \_\_\_\_\_  
TREATMENT IS ADVISED AND IN PROCESS \_\_\_\_\_  
TREATMENT IS COMPLETED \_\_\_\_\_

MALOCCLUSION IS PRESENT \_\_\_\_\_  
MALOCCLUSION IS NOT PRESENT \_\_\_\_\_

ORTHODONTIA IS IN PROGRESS \_\_\_\_\_

OTHER COMMENTS  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE: \_\_\_\_\_

\_\_\_\_\_  
(DENTIST'S SIGNATURE)

\_\_\_\_\_  
(DENTIST'S NAME PRINTED)

\_\_\_\_\_  
(DENTIST'S ADDRESS)

\_\_\_\_\_  
(DENTIST'S PHONE #)

