# AUBURN ENLARGED CITY SCHOOL DISTRICT
# SCHOOL HEALTH SERVICES
## Pre-Kindergarten and Kindergarten Registration Health Form

**Student Last Name:** _____ **Student First Name:** _____

**Date of Birth:** _____ **Place of Birth:** _____

**Sex:** **M**___ **F**___ **Grade:** *(circle one)* **3PK** **UPK** **K** **School:** _____

**Student Address:** _____

In case of accident or illness, it is mandatory that you provide the following information for emergency calls:

| Name | Last | First | Address | Home/Cell Phone | Work Name | Work Phone |
|---|---|---|---|---|---|---|
| Mother | | | | | | |
| Father | | | | | | |
| Step Parent | | | | | | |
| Step Parent | | | | | | |

List TWO persons (relatives/babysitter/neighbor) who will assume temporary care of your child if you cannot be reached:

| Name | Relationship | Address | Home/Cell Phone | Work Name | Work Phone |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Physician Name:** _____ **Dentist Name:** _____

**MEDICAL HISTORY**

***Has child, or any immediate family member (Parents/Grandparents) had a history of:***

Diabetes _____
Heart Disease _____
Seizures _____
Sickle Cell Trait _____
Sudden Cardiac Death _____

***Has child had: (Provide dates)***

RSV _____ Scarlet Fever _____
Chicken Pox _____ Rheumatic Fever _____
Pneumonia _____ Pertussis _____

Surgery _____ Serious Injury _____
Broken Bones _____ Head Injury _____
Loss of Consciousness _____

***Does child have any problem with:***

Constipation _____ Diarrhea _____ Bedwetting _____
Frequent Urination _____ Is your child potty trained _____

***Does child contract frequent: (More than 4-5 per year)***

Sore Throats/Strep Infections _____

Earaches/Ear Infections _____ Under care of Dr. _____

Tubes in ears _____ Date of insertion _____

Skin Rashes/Eczema _____

Headaches _____ Stomachaches _____

***Does child have:***

Asthma/Wheezing _____

Under care of Dr. _____ Medication _____

Allergies: *(circle all that apply)* Food Insect bites Medications Other

Describe allergens/reactions: _____

**Has child ever been stung by a bee?** Yes ____ No ____

If yes, describe reaction: _____

Heart Murmur _____ Under care of Dr. _____

Seizure Disorder _____ Under care of Dr. _____

Medication _____ Date of last seizure _____

Vision Problems _____

Under care of Dr. _____ Glasses: Yes ____ No ____

Last appointment _____

Hearing Problems _____

Under care of Dr. _____ Hearing aids: Yes ____ No ____

Last appointment _____

Are there any other medical problems or concerns that the school should be aware of: _____

_____

_____

Does child take any medication on a regular basis? _____

_____

In case I cannot be reached, I authorize the Auburn School District to render such treatment as may be necessary in an emergency for the health of my child. I give my permission to the school official in charge to obtain the services of the nearest ambulance, rescue service, family physician on record, or other physician if my own is not available, to provide immediate and necessary care. This form will be utilized for the current school year. The information will be shared with appropriate instructional staff, the transportation department, and Health Services. It will also be available on field trips and in the event of an emergency will be given to emergency personnel.

**Date:** _____ **Signature of Parent/Guardian X** _____

* If any of the above information changes during the course of the school year, please notify the School Nurse, as soon as possible. ***NYS Education Law requires school districts to have on file signed instructions for emergencies from parents/guardians.***

***For Office Use Only***

*If **Kindergarten Registrant**, did parent/guardian provide:*

Physical Exam ___ Date of Exam: _____

Dental Certificate ___ Date of Exam: _____

Immunizations ___ Up to date: _____

**Reviewed by: (Nurse)** _____

**Date of Interview/Form Completion:** _____

___ Release of Information signed

___ Renewed-Received Emergency Action Plan (date: ____)

___ Reviewed and Received Medication Policy and Order Sheet

___ Reviewed Immunizations, Physical and Dental requirements

***Revised: 01/24/2017***

RELEASE OF INFORMATION FORM TO ASSIST PARENTS IN OBTAINING HEALTH INSURANCE COVERAGE FOR THEIR CHILDREN ATTENDING AUBURN ENLARGED CITY SCHOOL DISTRICT

The purpose of this release is to allow the Cayuga County Health and Human Services (CCHHS) Department, Auburn Enlarged City School District (AECSD), and the Cayuga-Seneca Community Action Agency (CSCAA) to better assist you and your children to get and maintain health coverage through the Marketplace.

By signing this release you will be allowing CCHHS, AECSD, and CSCAA to share the confidential information listed below. This information may be further disclosed to the Cayuga County Health and Human Services Department and navigators at CSCAA so they can also assist in ensuring your child(ren)'s uninterrupted coverage. A navigator is someone who can assist you to enroll in a health insurance plan. **The information will only be shared to the extent that it is necessary or helpful to achieve this goal.**

The information disclosed will be limited to:

- My name and names of persons living in the household.
- Phone number

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

My child(ren) have health insurance at this time: ❑ Yes ❑ No

**RELEASE**

I hereby give CCHHS, AECSD, and CSCAA permission to share the above information between themselves on my behalf. I also give my permission to the AECSD to share this information to CCHHS and CSCAA, only to the extent of helping me get or maintain my health insurance coverage. I understand that any information released on my behalf may not be further disclosed without my written permission.

I may revoke (cancel) this release at any time by writing AECSD, Caren Radell, Nurse Supervisor, 78 Thornton Ave., Auburn, NY 13021. Such revocation will not affect any previous actions already taken.

_____ _____ _____

(Signature of Parent/Guardian or Student over 18) (Phone Number) (Date)

_____ _____

(Print Name) (Relationship to student)

☐ I do not wish to participate in this insurance program. (Optional)

*For Office Use Only Attn: Health Services Department – please forward completed document to Central Registrar, District Offices.*

____ Reviewed by Registrar

Forwarded to Student Services: Yes____ No____

New York State Department of Health
AIDS Institute

# Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☒ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

**PLEASE FILL OUT THE HIGHLIGHTED FIELDS ON BOTH PAGES**

Name and address of facility/person disclosing HIV-related information: (Doctor/Facility)

Name of person whose information will be released: (Student)

Name and address of person signing this form (if other than above): (Parent/Guardian)

Relationship to person whose information will be released: _____

Describe information to be released: Medical

Reason for release of information: School accommodations

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any: _____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences): _____

Please sign below only if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

## Authorization for Release of Health Information and Confidential HIV-Related Information*

**Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

Auburn Enlarged City School District

78 Thornton Avenue, Auburn, New York 13021

Reason for release, if other than stated on page 1:

N/A

If information to be disclosed to this facility/person is limited, please specify:

N/A

Name and address of facility/person to be given general health and/or HIV-related information:

N/A

Reason for release, if other than stated on page 1:

N/A

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____

(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

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# 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: ☐ M ☐ F | DOB: |
| School: | Grade: | Exam Date: |

## HEALTH HISTORY

| | |
|---|---|
| **Allergies** ☐ No<br>☐ Yes, indicate type | Type:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| **Asthma** ☐ No<br>☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other :<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| **Seizures** ☐ No<br>☐ Yes, indicate type | Type: Date of last seizure:<br>☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| **Diabetes** ☐ No<br>☐ Yes, indicate type | Type: ☐ 1 ☐ 2<br>☐ Medication/Treatment Order Attached ☐ 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 |
|---|---|---|---|
| TB- PRN | ☐ | ☐ | |
| Sickle Cell Screen-PRN | ☐ | ☐ | |
| **Lead Level Required Grades Pre- K & K** | | | **Date** |
| ☐ Test Done ☐ Lead Elevated ≥5 µg/dL | | | |

**List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)**

☐ **System Review and Abnormal Findings Listed Below**

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine | ☐ Skin | ☐ Social Emotional |
| ☐ Neck | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ 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/ | ☐ Yes ☐ No | ☐ |
| Near Vision Acuity | 20/ | 20/ | | ☐ |
| Color Perception Screening ☐ Pass ☐ Fail | | | | ☐ |
| 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** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes ☐ No | ☐ |
| Notes | | | | |

| **Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7 | **Negative** | **Positive** | **Referral** | **Not Done** |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ Yes ☐ No | ☐ |

**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, prostectic, 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.**

# Auburn Enlarged City School District

ADMINISTRATIVE OFFICES
78 Thornton Avenue, Auburn, N.Y. 13021-4698

## 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.