SMITHTOWN CENTRAL SCHOOL DISTRICT
Smithtown, New York 11787

ENROLLMENT FORM

Student Name: _____ Phone: _____

Address: _____ Town: _____ Zip _____

Nearest Street Intersection to Home: _____

Date of Birth: _____ Gender: _____ Place of Birth: _____
City State/Country

Entering School _____ Grade _____ Foreign Exchange Student _____

Has child attended the Smithtown Central School District previously? _____

If Yes, list School, Grade, Year: _____

Previous Out of District School Attended: _____

_____
Address Grade(s)

Guardian 1 Name: _____ Guardian 2 Name: _____

Guardian 1 Relation: _____ Guardian 2 Relation: _____

Employer's Name: _____ Employer's Name: _____

Employer's Address _____ Employer's Address _____

Cell Phone #: _____ Cell Phone #: _____

E-Mail Address: _____ E-Mail Address: _____

ETHNICITY (must select one):
Hispanic Origin ☐
Not Hispanic Origin ☐

RACE (must select at least one):
African American ☐
American Indian / Alaskan Native ☐
Asian ☐
Native Hawaiian /Pacific Islander ☐
White ☐

RESIDENCY/HOUSING:
Other Situation ☐
Abandoned Apartment ☐
In a Motel/Hotel ☐
In a Shelter ☐
Temporary Housing ☐
Train/ Bus Station ☐
With Relative ☐
Permanent Housing ☐
Train/Bus/Car ☐
Park/Campsite ☐

Languages spoken in the home: _____
Mailing required in a language other than English? ☐ Yes ☐ No

Are there any Divorce, Separation, Guardianship or Adoption issues? ☐ Yes ☐ No
Parent I.D.: _____

12/20

_____
Signature of Parent / Guardian

Smithtown Central School District
Yearly Health Survey

Student Info

School: ____________________

Student Name: ____________________ **Student ID:** __________
Street: ____________________ **Gender:** __________
City, State Zip: ____________________ **Grade:** __________
Home Phone: ____________________ **Date of Birth:** __________
Mailing Street: ____________________
Mailing City, State Zip: ____________________

PARENTS: Please make any necessary changes and/or additions, sign back and return.

- -

The health office will not release a student to anyone other than those listed below.

Father

Custody (Yes/No): ____________________
Name: ____________________
Other Info: ____________________
Beeper: ____________________
Cell Phone: ____________________
Business Address: ____________________
Daytime Phone: ____________________

Mother

Custody (Yes/No): ____________________
Name: ____________________
Other Info: ____________________
Beeper: ____________________
Cell Phone: ____________________
Business Address: ____________________
Daytime Phone: ____________________

Guardian

	Guardian 1	Guardian 2
Custody (Yes/No):		
Name:		
Other Info:		
Relationship:		
Daytime Phone:		

Medical

Doctor Name: ____________________
Doctor Phone: ____________________
Dentist Name: ____________________
Dentist Phone: ____________________

Emergency Contact Information

1	**Name:**	
	Relationship:	
	Phone:	
2	**Name:**	
	Relationship:	
	Phone:	
3	**Name:**	
	Relationship:	
	Phone:	
4	**Name:**	
	Relationship:	
	Phone:	

Please update the medical information on the back of this form.

Please verify the information below and update if necessary.

Past Year Illness

Has your child had any illness or operations during the past year ? Yes ☐ No ☐

Explain: _____

Previous illnesses or operations on record: _____

Understand Better

Is there anything concerning the general health of your child which would aid the School in a better understanding of this student ? Explain: _____

Previous comment on record: _____

Medications

Name	Dosage	Frequency

Eyes/Ears

Glasses (Yes/No):
Re-Exam Date:
Contact Lenses:
Re-Exam Date:
Hearing Problem (Yes/No):

Other

Allergies

Allergies (Yes/No):
Explain:

Asthma

Asthma (Yes/No):
Explain:

Email

Parent email: **Please supply one parent email address, for internal use only.**

Note: All new entrants and students entering grades 2, 4, 7 & 10 will require a physical examination during the calendar year.

Parents Signature: _____ **Date:** _____

12/12

A signed copy of this form must be returned for every student.

Smithtown Central School District

26 New York Avenue, Smithtown, New York 11787

Mark Secaur, Ed.D.
Superintendent of Schools
(631) 382-2006

Dear Parent or Guardian:

New York Education Law requires all students in kindergarten, grades 1,3,5,7,9 and 11, and all students new to the Smithtown Central School District to have a physical exam completed by their healthcare provider. There is a physical exam form available on the District's website: www.smithtown.k12.ny.us. This form is used for all students, kindergarten through grade 12. If your child is in grades 7-12 this physical can be used as a SPORT PHYSICAL if it is accompanied by the one page health history form (which parents fill out) also available on the website.

Changes in the New York State Education Law require that BODY MASS INDEX and WEIGHT STATUS GROUP be determined and documented on physical exams. This information will be reported to the NYS Department of Health as part of a survey when requested. No individual names are reported. Parent/guardians who CHOOSE NOT to have their students' information included in the survey MUST COMPLETE THE BOTTOM OF THIS LETTER AND RETURN IT TO YOUR CHILD'S SCHOOL HEALTH OFFICE.

When New York State Education Law requires a physical exam for your child, a request will be made for a DENTAL CERTIFICATE at that time. Dental certificates are available in your school's Health Office for you to take to your child's dentist. Once completed it should be returned to the School Nurse. The dental certificate can also be downloaded from the District's website.

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

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

Thank you,

Mark Secaur, Ed.D.
Superintendent of Schools

Please do not include my child's weight status information in the yearly New York State School Survey.

_____	_____	_____
Print Child's Name	Grade	Date
_____	_____	
Print Parent/Guardian Name	Parent/Guardian Signature	

Smithtown Central School District
Smithtown, New York 11787

HEALTH HISTORY

Student's Name _____ School _____

Please check the illness your child has had (Dates if possible): _____

Chicken Pox _____ Diabetes _____

Communicable Disease _____ Epilepsy _____

Scarlet Fever _____ Heat Disease _____

Ear Infections _____ Frequent Cold, Sore Throats _____

Pneumonia _____ Asthma _____

Allergies (medication/food/environment/etc) _____

Tuberculosis or contact with T.B. _____

Date of last T.B. test _____ Result _____

Operations _____

Serious Injuries _____

Any handicapping conditions _____

Medications _____

Does your child have an eye problem? _____

Under treatment with? _____

Does your child have a speech problem? _____

Does your child have a hearing problem? _____

Under treatment with? _____

Does your child have Scoliosis? _____

Under treatment with? _____

Any further information regarding your child that will assist us in their care: _____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

☐ Male
☐ Female

PARENT / PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other	_____ *specify*	
2. What was the first language your child learned?	☐ English	☐ Other	_____ *specify*	
3. What is the Home Language of each parent/guardian?	☐ Mother _____ *specify*	☐ Father _____ *specify*	☐ Guardian(s) _____ *specify*	
4. What language(s) does your child understand?	☐ English	☐ Other	_____ *specify*	
5. What language(s) does your child speak?	☐ English	☐ Other	_____ *specify*	☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other	_____ *specify*	☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other	_____ *specify*	☐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes ☐ ***No*** ☐ ***Not sure*** ☐ ***If yes,** please explain:_____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ **No** ☐ **Yes*** **Please complete 10b below*

10b. *If referred for an evaluation, has your child ever *received* any special education services in the past?

☐ **No** ☐ **Yes – Type of services received:**_____

Age at which services received *(Please check all that apply):*

☐ **Birth to 3 years (Early Intervention)** ☐ **3 to 5 years (Special Education)** ☐ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ☐ **No** ☐ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:

Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ☐ **Mother** ☐ **Father** ☐ **Other:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: NO YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
- ADMINISTER NYSITELL
- ENGLISH PROFICIENT
- REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING | EMERGING | TRANSITIONING | EXPANDING | COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Smithtown Central School District

26 New York Avenue, Smithtown, New York 11787

Mark Secaur, Ed.D.
Superintendent of Schools
(631) 382-2006

TO: Parent/Guardian of _____

RE: Special Education/Special Services

Was your child in any special education program or in need of any special services?

YES ☐ NO ☐

Parent/Guardian Signature _____

Is your child currently receiving Early Intervention (EI) services?

YES ☐ NO ☐

Parent/Guardian Signature _____

SMITHTOWN CENTRAL SCHOOL DISTRICT
Joseph M. Barton Building
26 New York Avenue
Smithtown, New York 11787

AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

Students Name _____ ID # _____

Date of Birth _____ Grade _____

Authorization is granted by the undersigned for the release of all official records, files and data directly related to the student named hereon to:

_____

_____

_____

_____

Materials for which release is authorized include all information and records that are intended for use in planning, evaluation and measurement of progress for educational purpose such as:

1. Academic work completed.
2. Level of achievement (grades, standardized test scores).
3. Attendance data.
4. Scores or standardized intelligence and aptitude tests.
5. Psychological tests and reports.
6. Interest inventory results.
7. Health data.
8. Family background information.
9. Teacher, counselor or agency ratings and observations.
10. Verified reports of serious and/or recurrent behavior patterns.
11. Committee on Special Education records.

Records are to be released by:

Name of School Official or Principal: _____

School: _____

Address: _____

Authorization is granted by:

Signature:_____Relationship: _____

Address: _____

Telephone Number: _____

Smithtown Central School District

26 New York Avenue, Smithtown, New York 11787

Mark Secaur, Ed.D.
Superintendent of Schools
(631) 382-2006

Immunization Compliance Notification

In accordance with the NYS Public Health Law §2164, 10NYCRR 66-1.3(c)(d) any student entering into Smithtown Central School District for the first time, or entering into a specific grade level that mandates a required immunization, must supply the school district with proof of immunization by the following means:

1. Proof of NYS required immunizations signed and stamped by a licensed medical practitioner.
2. Proof by letter, signed and stamped by a physician, stating that student is in process and will receive the required immunizations on NYS recommended Catch-up Schedule.
3. Proof of a medical exemption, signed and stamped annually, by a licensed medical practitioner.

This documentation must be received by smithtown Central School District within 14 days of the students entrance into school or extended to 30 days for any student who enters the school district from either out of NY state or out of the United States.

If Smithtown Central School District does not receive the required proof of immunizations listed above, the student will be excluded from school and the Suffolk County Department of Health will be notified.

A schedule of required immunizations is posted on the school district's website as well as provided upon request.

If assistance is needed in having your child immunized, please contact your child's school nurse or building principal. Every effort will be made to help assist parents/guardians with this process.

2020-21 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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**		

NEW YORK STATE | Department of Health

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 grade 6: 10 years; minimum age for grades 7 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 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 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. 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 grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks).

   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) 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

Smithtown Central School District

26 New York Avenue, Smithtown, New York 11787

Mark Secaur, Ed.D.
Superintendent of Schools
(631) 382-2006

Health Examination Requirements

Dear Parents/Guardians,

New York State has changed the mandated health examination requirements as of July 1, 2018. New York State law requires a health examination for all students entering the school district for the first time and when entering grades K, 1, 3, 5, 7, 9, and 11. The examination must be completed by a New York State licensed physician, physician assistant, or nurse practitioner.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K, 1st, 3rd, 5th, 7th, 9th, and 11th grades. If a copy is not given to the school within 30 days, arrangements will be made for your child to see the school physician.

- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.

We suggest you make copies of the completed forms for your own records before sending them to your child's school health office.

If you have any questions or concerns, please feel free to contact your child's school nurse.

Sincerely,

Smithtown School Nurses

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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 ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

Smithtown Central School District

26 New York Avenue, Smithtown, New York 11787

Mark Secaur, Ed.D.
Superintendent of Schools
(631) 382-2006

Dear Parent or Guardian:

New York State has recently passed a law requiring schools to request Dental Certificates for the following grades: Kindergarten, 1, 3, 5, 7, 9, and 11, as well as new students entering the District. Please have your child's dentist complete the bottom of this letter and **return it to the Health Office of your child's school as soon as possible**.

Should you have any questions, do not hesitate to call your school's Health Office.

Thank you for your attention to this matter.

Mark Secaur, Ed.D.
Superintendent of Schools

EXAMINER'S CERTIFICATION OF DENTAL EXAMINATION

School _____

Student _____ in grade _____ had a

Complete dental examination on _____ / _____ / _____

Treatment needed? Yes _____ No _____

Recommendations and Remarks _____

_____

Examiner's Signature and Stamp _____

Date _____ / _____ / _____

RETURN TO YOUR CHILD'S SCHOOL HEALTH OFFICE