

Babylon Union Free School District

50 Railroad Avenue
Babylon, New York 11702
Phone (631) 893-7900

www.babylonschools.org



As part of your child's requirements for school, a physical examination has been required for students in **Pre-Kindergarten or Kindergarten** and in **Grades 2, 4, 7, and 10**.

Currently, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a certificate enclosed for you to take to your child's dentist. Once it is completed, please return it to the Health Office as it will be filed in your child's Cumulative Health Record. A list of dentists to which children who need comprehensive dental examinations on a reduced cost basis is available upon request.

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

Please call or e-mail the Health Office in your child's school if you have any questions or concerns. The respective contact information is as follows:

Patrice Bagdanoff, R.N.
Babylon Elementary School Nurse
Office: (631) 893-7966
pbagdanoff@babylonufsd.org

Nina Burke, R.N.
Babylon Memorial Grade School Nurse
Office: (631) 893-7987
nburke@babylonufsd.org

Grace McHugh, R.N.
Babylon Junior-Senior High School Nurse
Office: (631) 893-7932
gmchugh@babylonufsd.org

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:
 Date of last tetanus _____

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: _____ Pulse _____ Date of Exam _____
 Heart _____ Lungs _____ Hernia _____ Extremities _____ Urinalysis: Albumin _____ Sugar _____

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

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:
 ___ Contact: baseball, basketball, football, hockey (field and ice), lacrosse, soccer, softball, wrestling
 ___ Non-contact: archery, bowling, cheerleading, field events, golf, other

___ Endurance Sports: cross country, gymnastics, swimming, tennis, track, volleyball

Did student participate in interscholastic athletics last year? Yes _____ No _____

Did student sustain serious injury or illness last year? Yes _____ No _____

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: _____

Dental Health Certificate- Optional

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: / / Sex: Male Will this be your child's first visit to a dentist? Yes No
 Month Day Year Female

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 _____

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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 1/4 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.