Newfane Central School District
Student Emergency Information

Child's Full Name: ______________________________
Date of Birth: ____________ Place of Birth (City, State): ____________

Legal Guardian #1's Name: ____________ Relationship: ____________
Guardian's Address: ____________ Home Phone: ____________
Guardian's Employer: ____________ Work Phone: ____________
Cell Phone: ____________ Nearest Phone (if no home phone): ____________
Email: ______________________________

Legal Guardian #2's Name: ____________ Relationship: ____________
Guardian's Address: ____________ Home Phone: ____________
Guardian's Employer: ____________ Work Phone: ____________
Cell Phone: ____________ Nearest Phone (if no home phone): ____________
Email: ______________________________

If natural parent is not legal guardian, please complete next section:
Father's Name: ____________ Any restrictions on release to this person? ____________
Mother's Name: ____________ Any restrictions on release to this person? ____________
Are there any custody issues, restricted release situations of which we should be aware?
____

Emergency Contacts (Adults to whom child may be released if legal guardian in not available)
Name #1: ____________ Relationship: ____________
Phone: Home: ____________ Work: ____________ Cell: ____________
Name #2: ____________ Relationship: ____________
Phone: Home: ____________ Work: ____________ Cell: ____________
Name #3: ____________ Relationship: ____________
Phone: Home: ____________ Work: ____________ Cell: ____________

Child's Usual Source of Medical Care
Name: ____________
Address: ____________
____
Phone: ____________
Last seen: ____________

Child's Usual Source of Dental Care
Name: ____________
Address: ____________
____
Phone: ____________
Last seen: ____________

Specialists: ______________________________
____

Child's Health Insurance
Name of Insurance Plan: ____________ ID# ____________
Subscriber's Name (on insurance card): ____________

Parent/Legal Guardian Consent and Agreement for Emergencies
As parent/legal guardian, I give consent to have my child receive first aid by school staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above receive health information and **to act on my behalf** until I am available. I agree to review and update this information whenever a change occurs.
Date: ____________ Parent/Legal Guardian's Signature: ____________

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Newfane Central School District
Sharing of Confidential Information

To ensure the safety and well being of your child while in our care, it is sometimes necessary to share your child's confidential health information with the staff that has direct care and responsibility for your child. We have found that most children in the younger age groups we service are not yet ready emotionally or physically to be responsible for identifying the need for and seeking appropriate medical interventions without adult guidance.

We attempt to provide child specific health care plans based on medical directions from your child's health care provider and developed with you, the parents, so that each child's individual needs are met at their level of need. We begin this process at registration with a review of your child's health care risks and needs. Further information may be requested from you and/or your child's healthcare provider to assist us in the development of your child's care plan. Please be assured that information shared is on a need to know basis, and is considered to be privileged and confidential by all of our staff. Staff may include, but is not limited to, the principal, teachers, instructional associates, school nurses, therapy providers, tutors, cafeteria staff, office staff, and bus drivers and aides and substitutes for all of these positions.

You have the right to restrict the information being shared with the staff that may have contact with your child during the school day as well as to restrict which staff may have access to this information. By signing below, you are giving us permission to share pertinent health information as needed to ensure that each staff person who has direct contact and responsibility for the care of your child is able to identify and appropriately respond to any special health care needs of your child. You have the right to rescind this consent at any time during the school year.

I, ______________________________, give consent for the school nurse to consult with my child's healthcare providers to develop a plan of care for my child and for release of pertinent information from my child ______________________________'s health history and health care plan with staff of the Newfane Central School District and Ridge Road Express who will have direct responsibility for the safety and care of my child, on a need to know basis as determined by the school nurse, or limited to the following staff:

____

______________________________ Parent's Signature/Date

______________________________ Parent's Signature/Date

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Newfane Central School District
Developmental History

Pupil's Name ______________________________ Sex ______ Birth Date ________________
(Last) (First) (Middle)

Prenatal / Pregnancy: Mother's age _____ Length of pregnancy _____ weeks Prenatal Care ___________

Adopted _______ At what age __________ Foster Care _______________ At what age ________________

Pre-existing maternal medical conditions, medications used during pregnancy (prescription, over the counter and recreational), accidents or injuries during pregnancy, lack of or late prenatal care. Problems: infections, bleeding, high blood pressure, anemia, gestational diabetes, fever, trauma, inherited disease, medication (other than iron, vitamins), chronic disease, hospitalization, swelling, other:

____

____

Labor and Delivery: Length of labor ____________________

Type of delivery: Vaginal ___________ Cesarean ____________ Forceps _____ Suction ______ Breech _____

Anesthesia / Medications: ____

Neonatal: Birth weight __________________ Premature _______________ Postmature ______________

Problems at birth or shortly after (breathing, infection, jaundice, bleeding, transfusions, antibiotics, birth defects, feeding, self temperature regulation, oxygen needs, blue spells, seizures, other): ____

____

Developmental: At what age did your child do the following: Sit alone _______ Roll over Unassisted_______

Stand alone ________Walk alone ___________ Sleep through the night __________________

Speech: Words:___________ Sentences: _________ Toilet trained: Urine _________ Stool _______________

Toileting assistance needed? _______What type? _____________Frequent accidents? Fecal _____ Urine ____

Diapers/Pull ups currently used? _______ When: ____

Feeding habits: Regular mealtimes? _______ Snacks? ___________ Over or Underweight for age? _________

Special diet needed? ___________________ Experience using utensils? ______________________________

Usual tv/computer/video game usage: ________ Usual amount of daily physical activity: _________________

Usual physical activities: ____________________________ Organized activities? ____________________

Difficulty with: Tying shoes ______ Using zipper _______ Using buttons ________ Dressing self _________

Using scissors ___________ Holding pencil/crayons __________ Mobility concerns ___________________

Usual bedtime __________ Usual # of hours of sleep ________ Naps: ______ Sleeps through night _________

Development: faster, slower, or equal to brothers/sisters/peers _____________ Dominant hand: _____________

Has your child ever been evaluated (other than well check-ups) **for concerns** with his/her:

Speech: ______ Fine or Gross Motor Abilities: _______ Behavior: _______ Vision: _______ Hearing: _______

Recommendations: ____

____

____

Please check the information that applies and add any pertinent information:

Allergies (specify reaction and allergen):
- Foods ______________________________
- Environmental/Seasonal: ______________
- Insects: __________________________
- Medications: ______________________

Accidents:
- a. Serious head injury ________________
- b. Loss of consciousness ______________
- c. Other (specify) __________________

Eye Difficulties:
- a. "Lazy eye" ______________________
- b. Glasses or contact lenses ____________
- c. Prosthesis _______________________
- d. Other (specify) __________________

Ear/Nose/Throat Problems:
- a. Frequent ear infections ______________
  - Age 0-2: ______ Current: ______
- b. Tubes __________________________
- c. Hearing loss _____________________
- d. Throat infections __________________
- e. Enlarged tonsils or adenoids__________
- f. Other (specify) ___________________

Heart Problems:
- a. Heart murmur ____________________
- b. Congenital heart disease ____________
- c. Rapid heartbeat/palpitations ___________
- d. Other (specify) ___________________

Respiratory Difficulties:
- a. Asthma _________________________
  - Triggers: ________________________
- b. Bronchitis/pneumonia _______________
- c. Cystic fibrosis ____________________
- d. Other (specify) ___________________

Kidney/Bladder/Bowel Difficulties:
- a. Kidney disease ____________________
- b. Bladder infections _________________
- c. Urinary reflux ____________________
- d. Enueresis (bedwetting) _______________
- e. Chronic constipation ________________
- f. Encopresis (fecal soiling) ____________
- g. Undescended (or one) testicle(s) _________

Musculoskeletal/orthopedic problems:
- a. Joint pain or swelling _______________
- b. Limitations of movement _____________
- c. Fractures ________________________
- d. Braces/wheelchair/adaptive equipment ____
- e. Prosthesis ________________________
- f. Other (specify) ____________________

Poor Coordination (specify): ______________
- a. Fine or gross motor delays (specify) ______

Birth Defects (specify): __________________

Hospitalizations / Operations (specify): _________

____

____

____

Illness with high fever (> 103°F): ___________
- a. Seizures ________________________
- b. Staring spells _____________________
- c. Tics ___________________________

Currently or regularly taken medication ________

____

Reason _______________________________

Is medication required in school? __________

Skin Conditions (specify): ________________

Mononucleosis _________________________

Tuberculosis (TB) contact ________________

Diabetes _____________________________

Hepatitis _____________________________

Thyroid disease ________________________

Gastric Reflux _________________________

Speech delay (specify): __________________

Emotional problems (specify): _____________

Attention problems (specify): ______________

Elevated lead level: _____________________

Other (specify): ________________________

____

Special Education Needs: ____

Does any close relative in your family have a history of: (Check and indicate relationship to this child.)

Diabetes __________	Cancer __________	High Blood Pressure_____	Birth Defect ________
Anemia __________	Epilepsy __________	Sickle Cell Anemia ______	Heart Disease ________
Learning Problems ____________	Mental Retardation ______________	Other ____________________	

Have there been any changes or additions to the family in the past year? (health problems, changes in marital status/custody, changes in occupation, new brother or sister, etc.) Explain: ____________________________

____

Signature ____ Date: ____________________

Parent/Guardian

NEWFANE CENTRAL SCHOOL DISTRICT HEALTH HISTORY

(To be completed by parent/guardian)

Student Name ____ Sex ______ Date of Birth ___/___/______

(Last, First, Middle Initial)

I. Life Threatening Allergic Conditions: (Check all that apply.)

[ ] Severe allergic reaction to Bee Stings, other insects: ____________________
[ ] Severe reaction to Nuts, Peanuts: ____________________
[ ] Severe reaction to other Food Products: ____________________
[ ] Other severe allergies affecting school: ____________________

Please indicate any of your child's symptoms which would indicate a severe allergy: (Local swelling does *not* indicate a severe allergic reaction.)

[ ] Itching and/or tightness in the throat, hoarseness [ ] Itching or swelling of the eyes, lips, tongue or mouth [ ] Hives
[ ] Shortness of breath, coughing, and/or wheezing [ ] "Thready pulse", "passing out"/loss of consciousness

Has your physician prescribed an Epi-Pen or other medicine for a severe life threatening allergy? [ ] Yes* [ ] No

Specify medication: ____________________

* If you answered "Yes", it is strongly advised that he/she have this medication at school. Carefully read the ***Medication Information*** below.

II. Health Conditions. Has your child been diagnosed with any of the following? Provide dates and details for all items checked "Yes".

Yes	No	Condition	Details/Dates
		Allergies to medications	
		Allergies (environmental or seasonal)	
		Anemia	
		Asthma/Reactive Airway Uses an inhaler? ___ Yes ___ No Uses a nebulizer? ___ Yes ___ No If your child uses an inhaler or a nebulizer, it is strongly advised that he/she have this medication at school. Carefully read the ***Medication Information*** below.	
		Attention deficit: ___ ADD or ___ ADHD Date diagnosed Meds: ___ Yes ___ No	
		Autism/PDD: ___Autism or ___Aspergers or ___PDD-NOS (not otherwise specified)	
		Behavior problem	
		Bleeding disorder	
		Bowel or digestive problem	
		Cancer, Type: ____________________ Date diagnosed	
		Cerebral Palsy	
		Chromosomal disorder: ___ Down's syndrome ___ Other – specify →	
		Cleft lip/palate	
		Cystic Fibrosis	
		Dental problem	
		Depression	
		Developmental Delay (learning, motor, speech) If yes, does your child receive special services? ___ Yes ___ No	
		Diabetes: Date diagnosed ______________ Insulin Dependent: ___ Yes ___ No	
		Eating disorder: Anorexia ___ Bulimia ___	
		Elevated lead level Date diagnosed ___________ Last tested ___________ Level ______	
		Emotional disorder	
		GERD Date diagnosed Meds: ___ Yes ___ No	
		Growth problems	
		Heart problem: specify →	
		Head Injury Type:	
		Hepatitis, Type: ____________________ Date diagnosed	
		Hernia Type:	
		High blood pressure	
		Hospitalizations: specify →	
		Immunodeficiency disease	
		Kidney or urinary problem	
		Lyme Disease	
		Muscular disorder	

Yes	No	Condition	Details/Dates
		Migraine headaches	
		Nutritional/weight problem	
		Orthopedic problem (bone, joint)	
		Pregnancy	
		Rheumatoid Arthritis	
		Scoliosis/abnormal spinal curve: Date of diagnosis Date of last evaluation	
		Seizure disorder, Type ________________ Date of last seizure:____________ Meds: ___ Yes ___ No. Medication ________________ (Please provide physician documentation of diagnosis.)	
		Self Harm/Mutilation	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Substance abuse (alcohol, drugs, tobacco)	
		Suicide risk or attempt	
		Surgeries: specify →	
		Thyroid disorder	
		Tics or twitches	
		Tourette's syndrome	
		Tuberculosis	
		Other	
		My child is healthy and has no special health needs.	

Yes	No	HEARING
		Hearing loss: [ ] Right - ___Mild ___ Moderate ___Severe [ ] Left - ___Mild ___ Moderate ___Severe Hearing loss due to ________________ Last evaluation ________________

Yes	No	VISION
		Color deficiency
		Legally blind
		Vision problem /Eye defect ________________ Last eye exam ____________
		Wears glasses [ ] All the time [ ] For distance only [ ] For reading only [ ] For sports
		Wears contact lenses

III. Medications: (Include all prescription, herbal and over-the-counter medication)

Name, dosage, route and frequency:	**Used to Treat:**

SCHOOL MEDICATION POLICY: If your child has a medical condition that requires medication in school, a written physician's order is required. No medication, including "over the counter" medications, may be carried by a student during regular school hours, at school-sponsored activities, such as field trips, *and* during after-school-hour activities. The only exceptions are for those students with asthma inhalers and Epi-Pens whose order specifies that they may "self administer" their medication and have been cleared by the school nurse. All medication must be delivered to the school Health Office by the parent/ guardian with the physician's original order and written parental permission. Medication order forms are available through the Health Office and on the District's website.

IV. Special Needs

Are there any other medical diagnoses or disabling conditions that might require a modification in your child's activities at school?
[ ] Yes* [ ] No Specify: ____

____

*** Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation before modifications can be considered.**

I understand that if my child's health status changes during the school year, I will provide the Health Office with updated information.
Parent/Guardian Signature ________________________________ Date ________________

NEWFANE CENTRAL SCHOOL DISTRICT

Education Law requires all students **enrolling in** the Newfane Central School District and all students entering **Pre-K or K** and in the **2nd, 4th, 7th, and 10th** grades present a Certificate of Health, including BMI weight status, signed by a duly licensed health professional in NYS. The school will provide a basic physical examination if a Certificate of Health is not received or an appointment with your personal physician has not been scheduled by 30 days after entry of grades in which physical examination is required.

As the school's physical is limited to cardiovascular fitness and a general assessment of ears and throat, it is recommended that parents have their child examined annually by their family physician. If you choose to have your child/children examined by your own physician, please have your doctor complete the attached form and return it to me.

A law was recently enacted that expands health screenings to include the dental health of students in NYS. After September 1, 2008 when we require a physical exam, we will be requesting a dental certificate, as well. There is a sample certificate attached that you may take to your child's dentist and once it is completed, it should be returned to the school nurse to be filed in your child's Cumulative Health Record.

Please let us know your plans by completing the information requested below and returning this letter to me by October 1st.

Thank you for your cooperation in this matter.

Sincerely,
Your School Nurse

☐ Newfane Early Childhood Center
Mrs. Teresa Trank, RN
Phone: (716) 778-6353
Fax: (716) 778-6868

☐ Newfane Middle School

Phone: (716) 778-6470
Fax: (716) 778-6460

☐ Newfane Elementary School
Mrs. Donna Winans, RN
Phone: (716) 778-6374
Fax: (716) 778-6377

☐ Newfane High School
Mrs. Lisa Erck, RN
Phone: (716) 778-6554
Fax: (716) 778-6578

Our plan for providing the required Certificate of Health for: ______________________________
Student's Name

______ Have our family physician examine our child. Appointment set for
____________________ with Dr. _________________________.

______ Certificate of health (physical examination) attached.

______ Have the school physician examine our child.

______ Requested dental appointment is set for __/__/__ with Dr. ________________

________________________________ ______________
Parent or Guardian Signature Date

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2022-23 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**		

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 grades 6, 7 and 8: 10 years; minimum age for grades 9 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 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 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. For children with a record of OPV, 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 grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) 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

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 ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ 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	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥5 µg/dL				

☐ **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: ☐ Additional Information Attached	Diagnoses/Problems (list) ICD-10 Code* *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.

NEWFANE CENTRAL SCHOOL DISTRICT

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: / / 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 him/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit him/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

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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Newfane Early Childhood Center
Dental Resources

The following dentists accept Medicaid in addition to other commercial insurance plans.
***Federally Qualified Health Center Clinics must offer income based sliding fee scale.

Advantage Dental
1909 Pine Avenue
Niagara Falls, NY 14301
Phone: 282-4641
Fax: 282-0958

Aspire Family Dental
5875 S. Transit Road
Lockport, NY 14094
Phone: 280-1001
Fax: 439-1918
or
1705 Pine Avenue
Niagara Falls, NY 14301
Phone: 284-0110
Fax: 284-0046

Choice One Dental
2878 Niagara Falls Boulevard
Amherst, NY 14228
Phone: 693-2861
Fax: 693-7028

Eastern Niagara Dentistry
57 Davison Court, Suite D
Lockport, NY 14094
Phone: 433-6111

Gasport Community Dental Care
8403 Rochester Rd.
Gasport, NY 14067
Phone: 772-5590

Robert McLanahann, DDS
200 Ontario Street
Buffalo, NY 14207
Phone: 876-1233
Fax: 876-1234

Niagara Cerebral Palsy
9812 Lockport Road
Niagara Falls, NY 14304
Phone: 297-1478
(Geared to developmentally disabled population, services provided by Mario Violante, DDS)

NFMMC Dental Clinic***
501 Tenth Street
Niagara Falls, NY 14302
Phone: 285-2993
Fax: 285-8993
(Medicaid only)

Niagara Quality Care Dentistry
8875 Porter Road
Niagara Falls, NY 14304
Phone: 297-5500 / 297-1100
Fax: 297-5559

Marti Peterson DDS
Just 4 Me Pediatric and Adolescent Dental Care
1660 Hopkins Road
Getzville, NY 14068
Phone: 688-7721

Frank Pallone, DDS
552 Third Street
Niagara Falls, NY 14301
Phone: 284-8148
Fax: 284-8598

Peter Purcell, DDS
401 Potters Road
West Seneca, NY 14220
Phone: 822-2499
Fax: 821-9672

UB School of Dental Medicine
Department of Pediatrics
150 Squire Hall
Buffalo, NY 14214
Adults: 829-2732
Children: 829-2723
Orthodontics: 829-2845
Fax: 829-3895

University Pediatric Dentistry
521 Buffalo Avenue
Niagara Falls, NY 14303
(Children only)
Phone: 282-5725
Fax: 282-4557
or
1660 Hopkins Road – Suite 107
Getzville, NY 14068
Phone: 688-7712
Fax: 688-4719
or
107 Squire Hall (Main & Bailey)
Buffalo, NY 14214
Phone: 836-5595
Fax: 833-3517

Dale Voelker, DDS
1050 Oliver Street
North Tonawanda, NY 14120
Phone: 693-0600

Women & Children's Hospital of Buffalo – Dental Clinic***
219 Bryant Street
Buffalo, NY 14222
Phone: 878-7758
Fax: 888-3942

The following local family dentists do not accept Medicaid. Other insurances accepted; many have payment plan options.

Aesthetic Associates Centre
2500 Kensington Avenue
Amherst, NY 14226
Phone: 839-1700

Aesthetic Dental Care
210 Bewley Building
Lockport, NY 14094
Phone: 434-8720

Amherst Dentistry
8588 South Transit Road
East Amherst, NY 14051
Phone: 636-1399

Barzman, Kasimov & Vieth
2430 North Forest Road
Amherst, NY 14068
Phone: 636-8686

Genene Crofut, DDS
2715 Millersport Highway
Amherst, NY 14068
Phone: 688-4501

James Ferington, DDS
233 East Avenue
Lockport, NY 14094
Phone: 434-1900
Fax: 434-1975

Peter Igoe, DDS
511 West Avenue
Medina, NY 14103
Phone: (585) 798-4040

Igor Kaplansky, DDS
8038 Rochester Road
Gasport, NY 14067
Phone: 772-7500

Todd Levine, DDS
5875 South Transit Road
Lockport, NY 14094
Phone: 439-1877

Lockport Dental Group
39 Elizabeth Drive
Lockport, NY 14094
Phone: 434-6004

Lockport Family Dental Care
120 East Avenue
Lockport, NY 14094
Phone: 433-7222

Newfane Family Dentistry
2727 Main Street
Newfane, NY 14108
Phone: 778-7449

Drs. Potempa, Dick & Riad
219 Hawley Street
Lockport, NY 14094
Phone: 434-0610
or
261 Young Street
Wilson, NY 14172
Phone: 751-9773

Barry Ruchlin, DDS
(Children Only)
9386 Transit Road
East Amherst, NY 14051
Phone: 639-7301

Sharing Smiles Family Dental Care
3039 Lockport Olcott Road
Newfane, NY 14108
Phone: 778-5150

Suburban Family Dental
646 North French Road
Suite 8
West Amherst, NY
Phone: 691-3520

Lawrence Volland, DDS
115 Professional Parkway
Lockport, NY 14094
Phone: 434-5571

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NIAGARA COUNTY HEALTH DEPARTMENT
IMMUNIZATION PROGRAM SERVICES

** ALL CLINICS ARE BY APPOINTMENT ONLY**

Hours: 9:00 – 11:30 am & 1:30 – 3:00 pm

Lockport

Trinity Lutheran Church
67 Saxton at LaGrange St.

Every 1st Friday (mornings)
Every 3rd Tuesday (mornings)

Niagara Falls

Trott Access Building
1001 11th Street, 3rd floor

Every 1st, 2nd and 4th Tuesday (full day)

IMMUNIZATION CLINICS FOR CHILDREN THROUGH 18 YEARS OF AGE:

- Bring your child and the child's immunization records to each appointment
- Parent or Guardian must accompany children under age 18. If parent is unable to bring their child to clinic, a responsible adult over the age of 18 may be sent. They must be provided with the child's immunization record and a signed permission slip stating who is bringing their child to the clinic and granting permission for their child to receive the necessary vaccines.
- Vaccines are **free of charge** through age 18 for children qualifying for the Vaccines for Children Program (VFC). This also applies to individuals 19 years of age and older if they are attending college and requires the MMR vaccine. Vaccines are also available for a fee to children and adults with private insurance who are not eligible for VFC vaccine.

SERVICES OFFERED:

Recommended and required immunizations such as: Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Varicella, HIB, Hepatitis B, Hepatitis A, HPV (girls & boys), Pneumococcal conjugate, Rotavirus, Typhoid, Meningococcal, Influenza and Rabies for pre-exposure for the disease.

Recommended and required immunizations for college students, if criteria are met.

Health & Insurance information provided, including Child Health Plus.

FOR INFORMATION ABOUT IMMUNIZATION CLINICS, ADULT, TRAVEL & FLU VACCINES – CALL 278-1903
PUBLIC HEALTH: PREVENT, PROMOTE. PROTECT.