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. Donna Winans, RN
Phone: (716) 778-6353
Fax: (716) 778-6868

☐ Newfane Middle House
Mrs. Lisa Erck, RN
Phone: (716) 778-6470
Fax: (716) 778-6460

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

☐ Newfane High School
Mrs. Sue Brown, RN
Phone: (716) 778-6554
Fax: (176) 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

NEWFANE CENTRAL SCHOOL DISTRICT
HEALTH CERTIFICATE / APPRAISAL FORM

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

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: _____

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: _____
PPD: ❑ Positive ❑ Negative ❑ Not done Date: _____
Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: _____ Result: _____
Dental Referral ❑ Yes ❑ No ❑ Not done Date: _____

Significant Medical/Surgical History: ❑ See attached _____

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension
❑ Other: _____

Allergies: ❑ **LIFE THREATENING** ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ . _____

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ Pass 20 db sc 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: _____

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:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❑ **Specify medical accommodations needed for school:** _____ ❑ SLP ❑ OT ❑ PT

❑ **Known or suspected disability:** _____ ❑ Please monitor

❑ **Restrictions:** _____

❑ **Protective equipment required:** ❑ Athletic Cup ❑ Sport goggles/impact resistant eyewear ❑ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/08*

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: Hearing loss due to _____ [ ] Right - ___Mild ___ Moderate ___Severe Last evaluation _____ [ ] Left - ___Mild ___ Moderate ___Severe

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 _____

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. Prothesis _____
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 Early Childhood Center
PreKindergarten/Kindergarten Registration Health Information

Dear Parent:
We would like for your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to the nurse at registration.

Pupil's Name _____ Sex _____ Birth Date _____
(Last) (First) (Middle)

Address _____ Phone _____

DEVELOPMENTAL HISTORY

Pregnancy: Mother's age _____ Length of pregnancy _____ weeks / Adopted _____ At what age ___

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 _____ Walk alone _____

Talk Words:_____ Sentences: _____ Toilet train: Urine _____ Stool _____

Toileting assistance needed? _____Frequent accidents? _____ Diapers/Pull ups currently used? _____

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: _____

(OVER)

Newfane Early Childhood Center
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: _____

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

School Health Requirements for New York State (Outside of New York City)

Health Requirement		Pre-Kindergarten	Kindergarten	Grades 1 through 5	Grade 6 and 7	Grades 8 through 12	Also Required at These Grade Levels
Health Appraisals		Required	Required if new entrant	Required if new entrant	Required if new entrant	Required if new entrant	2, 4, 7, 10th grades
Dental Certificate*		Requested	Requested if new entrant	Requested if new entrant	Requested if new entrant	Requested if new entrant	Requested at 2, 4, 7, 10th grades
Immunizations	Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine	4 doses	4 to 5 doses	4 to 5 doses	3 doses	3 doses	
	Tetanus and Diphtheria toxoid-containing vaccines and Pertussis vaccine booster	N/A	N/A	N/A	1 dose	1 dose	Students entering in grades 6 to 12 who have not previously received a Tdap at 7 years of age or older
	Polio	3 doses	3 to 4 doses	3 to 4 doses	3 to 4 doses	3 doses	
	Measles, Mumps, Rubella	1 dose	1 dose, 2 doses required by age 7	2 dose	2 doses	1 dose	
	Hepatitis B	3 doses	3 doses	3 doses	3 doses	3 doses	
	Varicella	1 dose	1 dose, 2 doses required by age 7	1 dose	2 doses	1 dose	
	Haemophilus influenza type B	1 to 4 doses	N/A	N/A	N/A	N/A	
	Pneumococcal Conjugate Vaccine	1 to 4 doses	N/A	N/A	N/A	N/A	
Blood Lead Level**		Requested	N/A	N/A	N/A	N/A	
Vision	Near Acuity	Required	Required if new entrant	Required if new entrant	Required if new entrant	Required if new entrant	
	Distance Acuity	Required	Required				1, 2, 3, 5, 7 and 10th grades
	Color Perception	Required	Required if new entrant	Required if new entrant	Required if new entrant	Required if new entrant	
Hearing Screening		Required	Required	Required if new entrant	Required if new entrant	Required if new entrant	1, 3, 5, 7 and 10th grades
Scoliosis Screening		N/A	N/A				5, 6, 7, 8, 9th grades

* Dental certificates are requested, not required, at any time a health appraisal is required.

** Blood lead testing should be done at ages 12 and 24 months. If level not provided by physician, schools must provide parents with information about lead poisoning and testing.

Immunization requirements updated 3/2015, and may be subject to change by NYS Department of Health. Immunization doses required are determined by age when started or ended, intervals between doses and type of vaccine given. Physician diagnosis of varicella and serologic evidence of measles, mumps, rubella, hepatitis B, varicella and / or polio antibodies is acceptable proof of immunity.

Rev. 3/2015

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
67 Saxton & LaGrange Streets
Every 1st Thursday (mornings)
Every 3rd Tuesday (mornings)

Niagara Falls
1001 11th Street, 3rd floor
Every 1st Tuesday (full day)
Every 4th Tuesday (mornings)

IMMUNIZATION CLINICS FOR CHILDREN THROUGH 18 YEARS OF AGE:

- Bring your child's immunization records to each appointment
- Parent or Guardian must accompany children under age 18
- Vaccines are **free of charge** through age 18 for children qualifying for the Vaccines for Children Program (VFC). Vaccines for children with commercial insurance vaccine coverage are available, but will incur a fee. Eligibility for vaccines through VFC will be determined at each clinic visit.

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 & Flu.
- 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.

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.

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

Louis Surace, DDS
37 Professional Parkway
Lockport, NY 14094
Phone: 433-3364
Fax: 433-7763

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

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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