H.E. 101 (Rev 07/12)

CITY SCHOOL DISTRICT OF ALBANY
BUREAU OF HEALTH AND PHYSICAL EDUCATION

HEALTH HISTORY AND REGISTRATION

SCHOOL _____ DATE _____ GRADE ENTERING _____

The information you provide on this form will become part of your child's Permanent Health Record. To protect your child and to help the District to appropriately respond to the health needs of your child, please answer all questions on **BOTH** sides of the form.
A certificate of immunization must be attached to this registration.

Child's Name (Last, First) _____ Sex _____ Date of Birth _____

Child's Address (No. and Street - Apt. No. - Zip Code) _____ Telephone Number/s _____

Father/Guardian _____ Mother/Guardian _____

Father/Guardian's Home and Work Telephone Nos. _____ Mother/Guardian's Home and Work Telephone Nos. _____

Emergency Contact #1 (Name, Relationship and Telephone Nos.) _____

Emergency Contact #2 (Name, Relationship and Telephone Nos.) _____

School Last Attended _____ Albany Public Schools Attended _____

Health Care Provider _____ Approximate Date of Last Physical Examination _____

Dentist _____ Approximate Date of Last Dental Examination _____

Insurance Information: Health Plan _____ ID/CIN # _____ Group # _____

BROTHERS AND SISTERS:

Name	Date of Birth	Grade/School

Note: For the safety and wellbeing of your child, you must be accessible in the event of illness or injury. Notify the school immediately if any of the emergency numbers or contacts you provided above change. It is not in the best interest of an ill or injured child to be maintained indefinitely at school. Parents must pick up their child when the child is ill or injured. If parents are unable to do so, they must designate a responsible adult to pick up and attend to their child.

OVER →

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If your child has had any of the following health problems or diseases, please check below and provide details in the comment column.

HEALTH HISTORY				COMMENT Please use this space to provide details for any condition/s checked.
Blood Disorders		Allergies		
Chicken Pox		Asthma		
Chronic Ear Infections		Birth Defects		
Hearing Loss		Bone/Joint Muscle Problems		
Hepatitis		Diabetes		
Mono		Heart Disease or Murmur		
Scarlet Fever/Strep		Lead Level Elevated		
Sickle Cell Disease		Operations/Hospitalizations		
Speech Problems		Seizure Disorders		
Tuberculosis		Serious Injuries		
Vision Problems		Other Health Issues		

Were there any complications during the pregnancy of this child? _____. If so, please describe. _____

_____.

What was the length of the pregnancy? _____ What was your child's birth weight? _____

Were there any complications during the birth of this child? _____. If so, please describe. _____

_____.

Does your child take any regular medications? If so, please list. _____

_____.

Does your child have any social or emotional problems that may impact his/her ability to learn and socialize in school? _____. If so, please explain. _____

_____.

New York State Education Law requires all new entrants and students in Pre-K or K, 2nd, 4th, 7th and 10th grades to have a physical exam. If a physical form is not returned to school before our school physicians come for physicals, your child will have a health appraisal in school.

Your signature authorizes health office personnel to share health related information with appropriate school staff when that information is necessary to insure the health and safety of your child.

_____
Parent/Guardian Name

_____
Parent/Guardian Signature

_____
Date

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **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

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

H. E. 105 (9/08)

CITY SCHOOL DISTRICT OF ALBANY
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Dental Health Certificate

Parent/Guardian: New York State Law requires school districts to request Dental Certificates for students when they enter school and in grades K, 2, 4, 7, and 10. Please complete Section 1 of this form and have your child's dental care provider complete Section 2. The dental assessment may be completed during or 12 months prior to the school year in which it is required. Return the completed form to the School Nurse/Teacher by *January 1st.*

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:		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

Section 2: To be completed by the Dental Care Provider

Child's Name: _____ Date of Exam: _____

The dental exam may be completed during or 12 months prior to the school year in which it is required.

Check one:

[] Yes - The student listed above is in fit condition of dental health to permit his/her attendance at school.

[] No - The student listed above is not in fit condition of dental health to permit his/her attendance at school.
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 school does not preclude the student from attending school.

Dental Care Provider's Name & Address: _____

_____

_____

Stamp:

Dental Care Provider's Signature: _____ Phone Number: _____

Oral Health Status (check all that apply).

Caries Experience/Restoration History: Has the child ever had a cavity (treated or untreated) or extraction?	**Yes**	**No**
Untreated Caries: Does this child have an open cavity?	**Yes**	**No**
Dental Sealants Present	**Yes**	**No**
Fluoride Supplements:	**Yes**	**No**

Other Observations (Specify): _____

_____

Treatment Needs (check all that apply)

No obvious problem. Routine dental care is recommended.
Immediate dental care is required.
Requires an appointment with a dentist for further care.
Date of Appointment: _____

CITY SCHOOL DISTRICT OF ALBANY
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Dear Parent or Guardian:

Poor dental health can cause pain, lead to significant life-long health problems, and can be a barrier to academic achievement.

New York State Law requires school districts to request Dental Certificates for students when they enter school and in **grades K, 2, 4, 7, and 10**.

Please take this form to your child's dental care provider to be completed. The dental assessment may be completed during or 12 months prior to the school year in which it is required.

Please return the completed form to your School Nurse/Teacher. The results will be maintained in the permanent health record.

If you have questions or do not have a dental care provider for your child, please contact the School Nurse/Teacher for assistance.

Thank you for your cooperation.

_____
School Nurse/Teacher

Telephone Number: _____