



Plattsburgh High School

1 Clifford Drive
Plattsburgh, New York 12901
Phone (518) 561-7500
Fax (518) 561-1895

John Fairchild, *Principal*
Glenn Hurlock, *Assistant Principal*

Dear Parent/Guardian:

To complete the registration of a new student at PHS you **must** provide **proof of immunizations**. You **must** also complete and sign the enclosed **medical history form**. New York State Education Law requires a **physical examination for all new students**, tenth grade students, students participating in interscholastic sports, and students with special health concerns. This physical examination would best be done by your family physician. However, physicals can also be done here at school by our district Nurse Practitioner. In addition to the Physical Exam requirement a new law recently came into effect asking all new students to submit a Dental Certificate to the School Nurse.

Included in this packet are:

1. Physical Exam Form

If you schedule a physical with your family doctor, have this form completed and return it to the Health Office.

2. Medical History Form

Please complete and sign this form. Information is needed to update your child's health record and must be returned before a school physical can be done.

3. Medication Form

This explains the medication policy for all medicines your student may need to take in school, including over-the-counter and prescription medications.

4. Dental Certificate

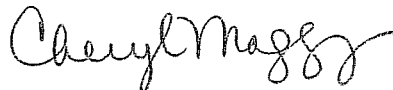
Please have a Dentist complete this form and return it to the School Nurse.

If you do not return a completed physical exam form or contact me I will automatically schedule your child for a school physical. School physicals are scheduled periodically throughout the school year.

If you have any questions please call me in the Health Office at 561-7500 extension #4.

Thank you for your cooperation.

Sincerely,



Cheryl Maggy RN
School Nurse

**Plattsburgh City School District
Health Services
Physical Examination Form**

To be completed when child is examined by family physician.

Name _____ School _____

Parent's Name _____ Grade _____

Eyes _____

Ears _____

Nose _____

Mouth & Throat _____ Tonsils _____

Lymph nodes _____

Heart _____ B.P. _____ P. _____

Lungs _____

Abdomen _____

Hernia _____

Genito-Urinary _____

Tanner stage _____ Menarche _____

Orthopedic: Structural _____ Scoliosis _____

Feet _____

Skin _____

Nervous System _____

Speech _____

Nutrition & Growth _____ Height _____ Weight _____

Chronic Illness _____

Immunization Received _____

Medications _____

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

Recommendations regarding school activities

(Physician's Signature)

(Physician's Name)

(Date of exam)

(Physician's Address)

MEDICAL HISTORY FOR PHYSICAL EXAM AND/OR ATHLETIC PARTICIPATION

Name _____ Date of Birth _____ Grade _____

Address _____ Health Care Provider _____

Sport(s): Fall _____ Winter _____ Spring _____

Check any of the following conditions, disorders or diseases that apply to the student.

_____ Asthma _____ Diabetes _____ Cystic Fibrosis _____ Thyroid Disease
_____ Blood Disease _____ Tourette's Syndrome _____ Mononucleosis _____ ADHD
_____ Kidney or bladder problem _____ Seizure disorder

Please indicate those conditions that the student has or has had in the past. Give month/year if known.

Head injury _____

Concussion _____

Knocked out, unconscious, or loss of memory _____

Numbness or tingling _____

Stinger/burner or pinched nerve _____

Frequent headaches _____

Eye or vision problems _____

Vision in one eye only _____

Glasses or contact lenses _____

Ear problems or hearing loss _____

Frequent ear infections _____

Hole in ear drum _____

Sinus infection _____

Frequent cold or sore throat _____

Dental bridge, brace, cap, or plate _____

Heart problem/murmur _____

Irregular heart/pulse rate _____

Chest pain, dizziness or passing out *during or after*

Exercise _____

Racing heart, palpitations or skipped heart beats *during*

Exercise _____

exercise _____

Blood relative died of heart problem or sudden death

Before age 50 _____

High blood pressure or high cholesterol _____

Severe viral infection within the last month _____

Trouble breathing or coughing during or after exercise _____

Dizziness or passed out in the heat _____

Spleen injury or condition _____

Stomach problems _____

Recurrent diarrhea _____

Age of first menstrual period _____

Absent or irregular periods _____

Disabling cramps with period _____

Absent or undescended testicle _____

Hernia _____

Any special educational needs? _____

Are there any significant family problems that we should be aware of? _____

Have there been any changes or additions in the family in the past year? (example: health problems, changes in marital status, change in occupation, new brother or sister) _____

Signature of Student _____ Date _____

Signature of Parent/Guardian _____ Date _____

I prefer: Private physical _____ School physical _____

Weight gain or loss in last year _____

Emotional problems _____

Stress, anxiety, depression _____

Skin condition _____

Allergies: Seasonal _____ Food _____

medicine _____ Beesting _____

Rash or hives after exercise _____

Hospitalization (date/reason) _____

Operation (date/reason) _____

Medication, pills, inhaler (prescription or OTC) _____

Supplements or herbals _____

Injury or problem: strain, sprain, dislocation, broken bone, swelling

Neck _____

Back _____

Chest _____

Shoulder _____

Upper arm _____

Elbow _____

Forearm _____

Wrist _____

Hand _____

Finger _____

Hip _____

Thigh _____

Knee _____

Shin/calf _____

Ankle _____

Foot _____

Special equipment: Knee or ankle brace, orthotics, protective cup _____

Neuromuscular problem(s) _____

Poor coordination/weakness _____

MEDICATION FORM

**PLATTSBURGH HIGH SCHOOL
HEALTH SERVICES**

Dear Parent/Guardian:

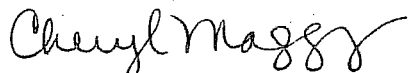
New York State Education Law requires a physician's written order for **all** medications at school.

In order for the school nurse to administer medication to the students, they must have:

1. Medication in original container.
2. Written parental permission.
3. Written order from a physician directing the nurse to give the medication including: the dosage, time/frequency and route of administration.

Please contact me at 561-7500 ext. 5031 with any questions you might have.

Sincerely,



Cheryl Maggy, RN
School Nurse

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Medication Request Form

Date: _____

Student's Name _____ Grade _____

Medication and Dosage to be Administered _____

Time medication is to be given _____ AM/PM

Dates medication is to be given _____

Condition being treated _____

Parental signature

Physician's signature

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: <input type="checkbox"/> Male	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Month Day Year	<input type="checkbox"/> 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 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.