



# ISLAND TREES PUBLIC SCHOOLS

HEALTH SERVICES  
Phone (516)520-2106  
FAX (516)520-0984

101 Owl Place, Levittown, New York 11756

To the Parent or Guardian:

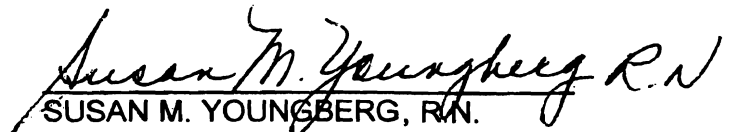
The New York State Department of Health recommends that every school child have an annual health examination in Kindergarten, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup> and 10<sup>th</sup> grades.

You are urged to take your child to your family physician and dentist as early as possible before school starts next September. Your family physician knows your child. He, therefore, can give your child a complete medical examination, vaccinations and other protective measures that are necessary. Your family physician will advise you concerning your child's health status and recommend the needed corrective measures. All remedial physical defects should be corrected as soon as possible.

Examination and treatment by the family dentist is an important part of the preparation for the school year. A clean healthy mouth helps to prevent illness and absence from school. The child should visit the dentist twice a year or as often as the dentist recommends.

For your convenience and in order to have the medical and dental examination done during the summer months, we are sending you the necessary state approved forms.

Thank you for your cooperation.

  
SUSAN M. YOUNGBERG, R.N.  
District Head Nurse

SMY:cl

May 2006

## **PARENTS PLEASE NOTE:**

It is now **REQUIRED** by the NYS Health Dept. that all children entering 7<sup>th</sup> grade have a BMI ( Body Mass Index ) and Percentile completed by their family doctor. This portion of the physical **MUST** be filled out or the form will **NOT** be accepted and you will have to return it to the doctor for completion.

**ISLAND TREES PUBLIC SCHOOLS**

**Medical/Athletic Physical**

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MALE/FEMALE GRADE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ LAST TETANUS VACCINE \_\_\_\_\_

MEDICAL/SURGICAL HISTORY \_\_\_\_\_

SPECIFY CURRENT CONDITIONS: ASTHMA \_\_\_\_\_ DIABETES 1 \_\_\_\_\_ DIABETES 2 \_\_\_\_\_  
PREHYPERTENSION \_\_\_\_\_ HYPERTENSION \_\_\_\_\_ OTHER \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ HEART RATE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

BLOOD PRESSURE \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

**REQUIRED BY NYS DEPT. OF HEALTH**

BODY MASS INDEX: _____ . _____	WEIGHT STATUS CATEGORY ( BMI PERCENTILE ): Less than 5 <sup>th</sup> _____ 5 <sup>th</sup> thru 49 <sup>th</sup> _____ 50 <sup>th</sup> thru 84 <sup>th</sup> _____ 85 <sup>th</sup> thru 94 <sup>th</sup> _____ 95 <sup>th</sup> thru 98 <sup>th</sup> _____ 99 <sup>th</sup> and higher _____
PRIMARY RACE/ETHNICITY : White _____ Black _____ Hispanic _____ Asian _____ Other _____	

Heart \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Lymph Nodes \_\_\_\_\_ Thyroid \_\_\_\_\_ Throat \_\_\_\_\_  
Teeth \_\_\_\_\_ Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_ Genito-Urinary \_\_\_\_\_  
Orthopedic \_\_\_\_\_ Skin \_\_\_\_\_ Nervous System \_\_\_\_\_ Speech \_\_\_\_\_ Scoliosis: Neg \_\_\_ Pos \_\_\_\_\_

This certifies that the above patient is physically qualified to participate in the following categories of competition during the school year. Please mark with an "X" all categories allowed.

- ( ) CONTACT/COLLISION SPORTS ( Football, Baseball, Basketball, Soccer, Wrestling, Lacrosse, Softball )
- ( ) ENDURANCE ACTIVITIES ( Track, Cross Country, Volleyball )
- ( ) OTHERS ( Bowling, Golf, Cheerleading, Kickline, Field Events )

Reason for disqualification

\_\_\_\_\_

Referrals: \_\_\_\_\_

Add any information you feel might be helpful in understanding or planning for this child:

\_\_\_\_\_

DATE : \_\_\_\_\_ PHYSICIAN'S SIGNATURE : \_\_\_\_\_

STAMP :

*This exam complies with NYSED requirements and is valid for 12 months, with the exception of any illness or injury lasting more than five days that will require review by private physician or specialist.*

ISLAND TREES ATHLETIC PERMISSION FORM

PART I

Parent/Legal Guardian complete Part I and II

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ SEX \_\_\_\_\_ GRADE \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

INTERSCHOLASTIC MEDICAL/SURGICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?		EXPLANATION	
Please check each item Yes or No	NO	YES	DATE(S)
1. Eye Disorder			
Loss of Vision in One Eye			
Detached Retina			
Cataract			
Contact Lens    ✓			
2. Ear Disorder			
Hearing Loss			
Tubes			
3. Nose Disorder			
Fractures			
Frequent Nose Bleeds			
4. Throat Disorder			
Tonsillectomy			
Thyroid Condition			
5. Dental Disorder, Braces, Caps, Bonding    ✓			
6. Heart Murmur, Rheumatic Fever			
7. Lungs Pneumonia, Bronchitis, Asthma			
8. Kidney, Bladder Disorder, Loss of Kidney			
9. Abdominal, Intestinal Disorders			
10. Hernia, Varicocele, Hydrocele			
11. Undescended Testicle, Loss of Testicle			
12. Bones/Joints, Fractures, Dislocation			
Chondromalacia, Osgood Schlatter			
Artificial Limb Splint/Brace			
13. Muscle Sprains			
14. Head Injury, Seizure Disorder			
Loss of Consciousness			
15. Allergies			
16. Prescribed Med.-Regular Basis/Dosage			
17. Operations			
18. Diabetes			
19. Hospital Admissions			

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PART II

PARENT: PLEASE SIGN YOUR FULL NAME next to EACH sport you will allow YOUR child to play in the coming year.

- |                      |                                 |
|----------------------|---------------------------------|
| *BADMINTON _____     | LACROSSE _____                  |
| BASEBALL _____       | SOCCER _____                    |
| BASKETBALL _____     | SOFTBALL _____                  |
| *BOWLING _____       | *SWIMMING _____                 |
| *CHEERING _____      | TRACK _____                     |
| *CROSS COUNTRY _____ | VOLLEYBALL _____                |
| FOOTBALL _____       | *WINTER TRACK _____             |
| *GOLF _____          | WRESTLING _____                 |
| *GYMNASTICS _____    | DATE OF LAST TETANUS SHOT _____ |
| *KICKLINE _____      | *INDICATES A H.S. LEVEL TEAM    |

STUDENT INSURANCE COVERAGE

The district's insurance coverage of student activities, at one time restricted to participants in interscholastic sports, is now extended to include all students participating in school sponsored activities - both curricular and co-curricular.

This is minimal coverage, however, because the Pupil Benefits Plan, sponsored by the New York State Public High School Athletic Association, the only accident insurance we are able to obtain, provides limited benefits. We strongly recommend, therefore, that parents examine their own medical insurance policies to be sure that adequate coverage is available, if needed.

✓ PERMISSION LETTER FOR CONTACT LENSES AND ORTHODONTIC APPLIANCES

My child, \_\_\_\_\_, has my permission to engage in all physical education programs and/or athletic activities while wearing his/her contact lenses and/or orthodontic appliances. I understand that there is a possibility of loss of or damage to the lenses or appliances during participation by my child in such activities. I recognize that the lenses and/or appliances can be lost, crushed or damaged during body contact activities and other vigorous exercise. I am willing to take calculated risks involved and assume responsibility for replacement of the above should they be lost or broken.

CONTACT LENSES

ORTHODONTIC APPLIANCES

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

School Year \_\_\_\_\_

**ISLAND TREES PUBLIC SCHOOLS  
LEVITTOWN, NEW YORK 11756**

Student's Name \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_

Room \_\_\_\_\_ Grade \_\_\_\_\_

**RECOMMENDATIONS OF FAMILY DENTIST**

This student is receiving dental treatment

This student requires no treatment at this time

Treatment has been completed

Examining Dentist :(Please Print or Stamp ) \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Dentist's Signature \_\_\_\_\_

**ISLAND TREES PUBLIC SCHOOLS  
HEALTH SERVICES**

The following regulations have been established by the School health council in order to control the spread of communicable disease, insure rapid recovery, and guard against complications.

It is advisable to keep a child home from school (and, if necessary, consult your family physician), when the child has any symptoms of illness including the following:

*Elevated temperature or chills  
Reddened or discharging eyes  
Nausea or vomiting  
Runny nose*

*enlarged glands  
skin eruption  
sore throat  
coughing*

*earache  
headache  
diarrhea  
dizziness*

The school nurse will require that a child who is ill be returned to the home. Transportation is not provided in these circumstances.

A child with a suspicious skin or scalp condition will be excluded from school until seen by a physician and treatment prescribed. A child with conjunctivitis must be excluded until a physician has approved attendance.

Children returning to school after recovery from a communicable disease will report to the nurse. If there is evidence of continued disease, the child will not be permitted to remain in school.

**NO CHILD MAY ATTEND SCHOOL USING CRUTCHES WITHOUT A DOCTOR'S NOTE STATING THE CHILD CAN ATTEND SCHOOL ON CRUTCHES WITHOUT HAZARD TO HIMSELF OR OTHERS.** If the injury necessitates a cast, a note must also state the date the student may return to school.

If transportation is needed, a SEPARATE PHYSICIAN'S NOTE should indicate if the request is for a regular bus or special transportation (door to door service). The note should also include the diagnosis and length of time for transportation. **STUDENTS ON CRUTCHES MUST HAVE SPECIAL TRANSPORTATION.** Such requests should be taken to the health office in Stokes School.

Upon return from an injury or illness, the student must report directly to the health Office and submit a note from a physician indicating the extent, duration and limitation of physical activity or physical education.

**STUDENTS ARE NOT ALLOWED, AT ANY TIME, TO CARRY ANY KIND OF MEDICATION ON THEIR PERSON.** Any medication to be taken during the school day must be administered by the school nurse, be kept in the Health Office, and be accompanied by a PHYSICIAN'S NOTE AND PARENT REQUEST for its administration. Forms can be obtained in the Health Office.

Home teaching is available. A PHYSICIAN'S NOTE requesting home teaching should be taken to the Health Office at Stokes School. A PHYSICIAN'S NOTE is required for the student to return to school.

First aid and first care for illness or injury that occur in school or on school grounds will be provided in school. First aid is immediate treatment only. Further care must be provided by the family or a physician.

Please do not send your child to the nurse for an opinion regarding an illness or injury. The members of the school health staff are not permitted to offer diagnosis, change dressings, or treat injuries other than to administer first aid.

These regulations have been established to protect the health and safety of all our school children.

HEALTH OFFICES: STOKES 520-2106  
SPARKE 520-2129

MIDDLE SCHOOL 520-2164  
HIGH SCHOOL 520-2148