REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	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	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
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	☐

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*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*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.

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
AT CENTEREACH
8 43RD STREET · CENTEREACH, NY 11720
631-285-8005 · 631-738-2719 (fax) · www.mccsd.net

Roberta A. Gerold, Ed.D., Superintendent of Schools
Francine McMahon, Deputy Superintendent for Instruction
Beth Rella, Assistant Superintendent for Business
James G. Donovan, Assistant Superintendent for Human Resources
Joseph Mercado, Director of Health, Physical Education & Athletics

ADMINISTRATION OF MEDICATIONS IN SCHOOL

_____ _____
Student's Name Grade and School

New York State Law states that medication can be given to a child during school hours **only if the school nurse receives a note from the child's physician with the physician's signature. All medication must be in the original container and clearly labeled** stating:

1. Name of medication;
2. Time medication is to be given, and dosage;
3. A request that it be dispensed in school, together with a note from the parent/guardian giving the school nurse permission to dispense the medication.
4. Medication must be in its original sealed container.

MEDICATION TO BE TAKEN IN SCHOOL must be taken to the nurse's office by the parent/guardian. PLEASE do not have medication in school for a child to take on his/her own. We have many children who are allergic to various drugs. If any of these drugs should unknowingly fall into their hands, the results could be **FATAL**.

We cannot accept notes that are stamped, or signed by anyone other than your child's physician.

Dear Parent/Guardian of _____

Your child was receiving medication during the school year. Enclosed is the form needed to be completed by your child's doctor for the next school year. Please return the completed form to your child's nurse in September. Medications must be taken to the nurse's office by the parent/guardian.

Thank you for your cooperation.

Dominika Leon, RN
Stagecoach Elementary School Nurse
Phone: 631-285-8744 Fax:631-285-8731

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

ADMINISTRATION OF MEDICATIONS IN SCHOOL

New York State Law requires that medications can be given during school hours only if the school nurse receives **a note from your doctor, including his/her signature (stamped signatures, nurse's signatures or secretary's signatures cannot be accepted)** stating:

1. Name of medication;
2. Time and dosage of medication to be given;
3. A request that it be dispensed in school, and a note from the parent giving the school nurse permission to dispense the medication;
4. The medication is in its original sealed container.

MEDICATION TO BE TAKEN IN SCHOOL must be taken to the nurse's office by the parent/guardian. **PLEASE** do not have medication in school for a child to take on his/her own. We have many children who are allergic to various drugs. If any of these drugs should unknowingly fall into their hands, the results could be **FATAL**.

Date: _____

To the Physician:

Please complete the following:

1. Child's Name _____
2. Name of Medication _____
3. Times to be given _____
4. Dosage to be given _____
5. Duration of time child is to receive medication _____

_____

Physician's Signature _____

We cannot accept a stamped signature, or a signature of a nurse or secretary.

_____
Office Stamp

To the Parent:

Please sign the following:

I hereby give my permission for the School Nurse to administer the medication as prescribed by my doctor for my child. All medication(s) must be taken to the nurse's office by the parent/guardian.

_____
Parent's Signature

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, Pre-K or K, 1, 3, 5, 7, 9, & 11. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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 oral health assessment? € 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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment)
The date of the assessment 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/ Dental Hygienist's name and address

(please print or stamp) **Dentist's/Dental Hygienist's Signature**

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):_____

II. 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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James G. Donovan, Assistant Superintendent for Human Resources
Beth A. Rella, Ed.D., Assistant Superintendent for Business
Jonathan Singer, Assistant Superintendent for Instruction

August 2024

Dear Parents and Guardians,

We are happy to announce that Middle Country CSD, **Stagecoach Elementary**, was selected to participate in the U.S. Department of Agriculture's (USDA) Fresh Fruit and Vegetable Program (FFVP) during the 2024-25 school year.

The goals of this grant program are to:

- Create healthier school environments by offering healthy choices.
- Expand the variety of fruits and vegetables children experience.
- Increase children's fruit and vegetable consumption.
- Make a difference in children's diets to impact their current and future health.

Beginning the week of September 16th, students in grades 1-5 will be offered a fresh fruit or vegetable to try twice weekly. FFVP snacks will generally be served outside your child's regularly scheduled lunch time.

A new FFVP menu will be available online on the MCCSD Food Service webpage each month. Participating classrooms will be provided with supplemental nutrition education material to increase students' knowledge of the health benefits of eating fresh fruits and vegetables. The FFVP is an excellent way to supplement other wellness programs in our schools that promote health, nutrition, and physical activity.

You can support your student's efforts to increase their fruit and vegetable consumption in many ways. For example:

- Take your student grocery shopping. Let your student select a new fruit or veggie to try.
- Give your student options! Let your student choose which veggie to serve at dinner.
- Keep fruits and vegetables where your student can see them, such as on the counter.
- Take your student to a local farmers' market and discover fruits and vegetables in season.
- Be a role model! Let your child see you regularly eating fruits and veggies.

If you have questions, please contact the district food service office at foodservice@mccsd.net, 631-285-8190, or visit MCCSD.net. Additional resource information is available at USDA Food and Nutrition Service U.S. Department of Agriculture, https://www.fns.usda.gov/ffvp

Sincerely,

Sharon Dyke
School Lunch Coordinator
Middle Country Central School District
14-43rd Street
Centereach, NY 11720
foodservice@mccsd.net

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
(2) fax: (833) 256-1665 or (202) 690-7442
(3) or email: program.intake@usda.gov.

This institution is an equal opportunity provider.

September

SAMPLE MENU ONLY 2024

MCCSD Primary Schools, All Students in Grades 1 -5

Monday	Tuesday	Wednesday	Thursday	Friday
2 *Labor Day*	3	4 *Welcome Back Students*	5	6
9	10	11	12	13
16	17	18 *Watermelon Chunks*	19	20 *Celery Sticks*
23	24	25 *Clementine*	26	27 *Honeydew Melon Chunks*
30				

Please review the menu before allowing your child to consume new foods.
Changes to this menu will be posted on the online menu.
Parents/Guardians may choose to have their child opt out of participating in this program.
The FFVP aims to introduce children to fresh fruits and vegetables, to include new and different varieties, and to increase overall acceptance and consumption of fresh, unprocessed produce among children.
For more information, visit MCCSD.net, Food Service Department webpage or contact The Middle Country School Lunch Office at (631) 285-8190, or email, foodservice@mccsd.net

Stagecoach Elementary PTA

2024
2025
SCHOOL YEAR

BECOME A MEMBER TODAY

PURCHASING A PTA MEMBERSHIP IS ONE OF THE MOST IMPORTANT THINGS YOU CAN DO FOR YOUR CHILD'S EDUCATION.

PTA membership and dues support your child by funding educational and curriculum needs and advocating on behalf of children and educators at the local, state, and national levels. ***Your paid membership is your child's voice!***

The PTA funds our school with valuable programs such as STEM, and PARP which provides access to art, reading, literature, dance and music as well as the National Circus Project and Family Fun Nights. The state and national PTA provides access to enrichment programs for educators. The PTA also provides support for children with special needs. Increasing our membership base directly impacts our benefits.

The only thing required of you to become a member is to pay your annual membership dues. Beyond that your level of involvement is completely up to you. ***Attending meetings or volunteering your time is not a requirement.***

Being a PTA member does allow you the opportunity to be engaged with your child's education, to volunteer at school events or to participate in local, state, and national advocacy efforts if you choose.

Your membership gets you exclusive discounts on tickets to school activities, family fun nights, yearbooks and spirit wear!

INDIVIDUAL MEMBERSHIP: $10

Stagecoach Elementary PTA
everychild. onevoice.

POINT YOUR PHONE CAMERA AT THE QR CODE OR VISIT:

STAGECOACH.MEMBERHUB.STORE

Scan here!

stagecoach205@gmail.com **StagecoachElementaryPTA** **StagecoachPTA**

THANK YOU FOR YOUR SUPPORT OF OUR SCHOOL & OUR CHILDREN *PLEASE PRINT CLEARLY*

STUDENT'S NAME:_____ **TEACHER'S NAME:**_____

☐ **CASH** ☐ **CHECK** *TOTAL AMOUNT ENCLOSED:*_____

MEMBER NAME	EMAIL ADDRESS	PHONE NUMBER

PLEASE MAKE CHECKS PAYABLE TO: STAGECOACH ELEMENTARY PTA