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

interscholast	ic sports; and w			ded; or as requi e-School Specia	1.5		ecial Edu	ıcation (CSE) or
			STU	DENT INFORMA	ATION			
Name:	lame: Affirmed Name					(if applicable):		DOB:
Sex Assigned at Birt	h: 🔲 Female	☐ Male		Gender Identit	y:	□ Male □	Nonbina	ary 🗆 X
School:						Grade:		Exam Date:
			ı	HEALTH HISTO	RY			
	If yes to any	diagnoses b	elow, ched	k all that apply	and provide ac	dditional info	rmation.	
☐ Allergies	Type:	edication/T	reatment	Order Attache	d □ Anaphy	laxis Care Pla	an Attach	ed
	☐ Interm		☐ Persiste					
☐ Asthma	☐ Medica	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached						
	Type:					ast seizure:		
☐ Seizures	2012-00	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached						
		Type: 1 2						
□ Diabetes □ Medication/Treatment Order Attached □ Diabetes Medical Mgmt. Plan At					lan Attached			
Risk Factors for Dial			10.00		The last section of the contract of the	Calleda Colle	200-200-200-200-200-2	
T2DM, Ethnicity, Sx I	nsulin Resistano	e, Gestatio	nal Hx of M	other, and/or pr	e-diabetes.			
BMIkg/m	2							
Percentile (Weight S	Status Category): 📮 <	5 th 🔲 5	th - 49 th	- 84 th □ 85 th	- 94 th 🔲 95 th	- 98 th	☐ 99 th and >
Hyperlipidemia:	☐ Yes ☐ No	t Done		Hyperto	ension: 🔲 Y	es 🔲 Not Do	one	
		Р	HYSICAL E	XAMINATION/	ASSESSMENT			
Height:	Weight:		ВР);	Pulse:		Respirat	ions:
Laboratory Testing	Positive	Negative	Date		Lead Lev Required for P		v	Date
TB-PRN				☐ Test Done ☐ Lead Elevated ≥5 μg/dL		ıp/dl		
Sickle Cell Screen-PRN	1 1000							
System Review \					,		101	
Abnormal Findin			Brancas con an					
	G (#8)	ymph nodes		☐ Extremities		□ Spe		
	☐ Cardiovascular ☐ Back/Spine/Neck ☐ Lungs ☐ Genitourinary		☐ Skin ☐ Social Emotion ☐ Neurological ☐ Musculoskeleta					
☐ Mental Health ☐ Assessment/Abno		1/Posommo		urinary			Livius	5-53
☐ Assessmenty Apric	ormanties Notec	ij Recomme	eridations.		Diagnoses/Pr	obiems (list)		ICD-10 Code*
☐ Additional Information Attached			*Required only for students with an IEP receiving Medicaid					

5/2023

Name:	Affirmed Name (if applicable):			DOB:	
		SCREENINGS	·		P
	Vision & Hearing Scree	nings Required for I	PreK or K, 1, 3, 5, 7,	& 11	1 = 1 = 100
Vision Wit	h Correction TYes No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	
Near Vision Acuity		20/	20/		
Color Perception Screening	Pass Fail				
Notes					* 1
Hearing Passing indicates for grades 7 & 11 also tes	student can hear 20dB at al t at 6000 & 8000 Hz.	l frequencies: 500,	1000, 2000, 3000, 4	4000 Hz;	Not Done
Pure Tone Screening	Right 🔲 Pass 🔲 Fail	Left 🔲 Pass 🔲 Fa	ail Refe	rral 🗆 Yes	
Notes					
		Negative	Positive	Referral	Not Done
Scoliosis Screening: Boys	grade 9, Girls grades 5 & 7			☐ Yes	
	FOR PARTICIPATION IN P	HYSICAL EDUCATION		GROUND/WORK	
☐ *Family cardiac histor	y reviewed – required for D	ominick Murray Su	dden Cardiac Arres	t Prevention Act	
Student may participa	ate in all activities without re	estrictions.		8	
	mplete the information belo				
Hockey, Lacros	ketball, Competitive Cheerlea se, Soccer, and Wrestling. orts: Baseball, Fencing, Softba :: Archery, Badminton, Bowlin	all, and Volleyball.			
	r Athletic Placement Proces ic sports level OR Grades 9-1				- 10000 10000 1000 000 000 000 000 000 0
Tanner Stage: 🔲 I 🗍 II					
☐ Other Accommodation below to explain.	ons*: (e.g., brace, orthotics,	insulin pump, prost	hetic, sports goggl	es, etc.) Use addit	ional space
*Check with the athletic gove	erning body if prior approval/fo	rm completion is req	uired for use of the o	levice at athletic co	mpetitions.
		MEDICATIONS			
	Order Form for	medication(s) need	ed at school attache	ed	
СО	MMUNICABLE DISEASE			IMMUNIZATIONS	5
☐ Confirmed fr	ee of communicable disease	during exam	☐ Record	Attached 🗆 Re	eported in NYSIIS
		EALTHCARE PROVI	DER		
Healthcare Provider Signatu	re:				
Provider Name: (please prin	t)				
Provider Address:			The state of the s	The state of the s	
Phone:		Fax:		The efficiency and designation of the second	
Pleas	e Return This Form to You	r Child's School He	ealth Office When	Completed.	

5/2023 Page 2 of 2



parent/guardian.

Thank you for your cooperation.

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

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 give school nurse receives a note from the child's phymedication must be in the original container and clear	sician with the physician's signature. All			
 Name of medication; Time medication is to be given, and dosage; A request that it be dispensed in school, toget giving the school nurse permission to dispense the med. Medication must be in its original sealed contains 	dication.			
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 b	y anyone other than your child's physician.			
Dear Parent/Guardian of				
Your child was receiving medication during the school completed by your child's doctor for the next school your child's nurse in September. Medications must	year. Please return the completed form to			

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 <u>note from the parent</u> 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.

be <u>FAT</u>	<u>'AL</u> .				
To the	Date:Physician:				
Please o	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:				
my do	by give my permission for the School Nurse to administer the medication as prescribed by actor for my child. All medication(s) must be taken to the nurse's office by the 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.

Sectio	n 1. To be comple	eted by Parent of	or Guardian (Please Print)	
Child's Name:		First	Middle		
Birth Date: / / Month Day Year	Sex: € Male € Female	Will this be your ch	nild's first oral health assessment?	' € Ye	es € No
School: Name					Grade
Have you noticed any problem in the mou	th that interferes with y	your child's ability to o	hew, speak or focus on school ac	xtivities? €	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 prelim Further, I will not hold the dentist or those recommendations listed below.	ninary oral health asses performing this assess	ssment does not esta sment responsible for	ıblish any new, ongoing or continu the consequences or results sho	uing doctor uld I choos	-patient relationship. se NOT to follow the
Parent's Signature			Date		
Sect	ion 2. To be com	pleted by the D	entist/ Dental Hygienist		
I. The dental health condition of The date of the assessment needs	to be within 12 mo	onths of the start o	on_ of the school year in which i	(date o	of assessment) (ested. Check one:
Yes, The student listed above is in the student listed above in the student listed above is a student listed above in the student listed above is a student listed above in the student listed above is a student listed above it is a student listed above in the student listed above it is a student listed above in the student listed above it is a student listed above i	fit condition of denta	al health to permit h	is/her attendance at the public	c schools	i .
No, The student listed above is not	in fit condition of de	ntal health to perm	it his/her attendance at the pu	ıblic scho	ols.
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	ase this information t	to your child's scho	ol, 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.					

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT



8 43RD STREET • CENTEREACH, NY 11720 631-285-8005 • 631-738-2719 (fax) • <u>www.mccsd.net</u>

> Roberta A. Gerold, Ed.D., Superintendent of Schools 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

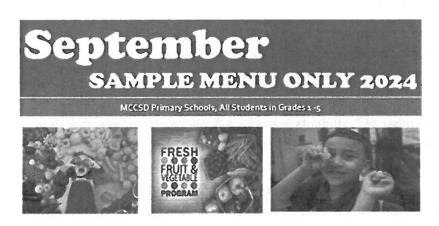
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal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



Manday	Tuesday	Wednesday	Thursday	Friday
Lebor Day	3	4 Welcome Back Students	5	6
9	30	21	ü	23
uf-	127	aS Watermelon Chunis	19	20 Celery Sticks
) ₃	34	25 Clementine	26	37 Hansydew Africa

Please review the menu before allowing your child to consume new foods.

Changes to this menu will be posted on the entire menu.

Perents/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 vertebes, and to increase overall acceptance and consumption of fresh, improcessed produce among children.

For more information, visit NECCSD.net, Food Service Department webpage or contact The Middle Country School Lunch Office at (%1) 3 JEC-80.0, or email, foodservice@firecsd.net

Stagecoach Elementary PT/4

BECOME 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.

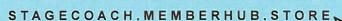
Being a PTA member does allow you the opportunity to be engaged with your child's education, to volunteer at school events or to participate in local, state, and national advocacy efforts if you choose.

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

INDIVIDUAL MEMBERSHIP: \$10



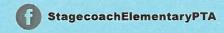
POINT YOUR PHONE CAMERA AT THE QR CODE OR VISIT:











현생님이 있는데 그는 아이들은 아이들은 아이들은 아이들은 아이들은 아이들은 아이들은 아이들은
THANK YOU FOR YOUR SUPPORT OF OUR SCHOOL & OUR CHILDREN PLEASE PRINT CLEARLY
THANK TOO FOR TOOK SUFFORT OF OUR SCHOOL & OUR CHIEDREN FLEASE FRINT CLEARLY

STUDENT'S NAME:	TEACHER'S NAME:	OF THE PERSON NAMED IN COLUMN TO THE
□ CASH □ CHE	CK TOTAL AMOUNT ENCLOSED:	
MEMBER NAME	EMAIL ADDRESS	PHONE NUMBER