ALTMAR PARISH WILLIAMSTOWN CENTRAL SCHOOL DISTRICT
CENTRAL REGISTRATION
639 County Route 22 • Parish, New York 13131
PHONE: (315) 625-5275
FAX: (315) 625-7952

Kathy Treat, RN
APW Elementary School

Sylvia Krupke, RN
APW Jr/Sr High School

MANDATORY HEALTH APPRAISALS FOR NEW & RETURNING STUDENTS

Dear Parents,

New York State requires that each student, within 30 days after his or her entrance into school, submit to the school nurse a health certificate/physical exam signed by a duly licensed physician, physician assistant, or nurse practitioner. This examination shall not have been given more than 12 months prior to the commencement of the school year in which the examination is required.

If you would like your child to have their physical performed at school, at no cost to you, **please indicate so below by signing permission & returning the form to your child's school nurse as soon as possible.** The APW school district has contracted with Pulaski Health Center to provide physical examinations for students at their respective buildings during school hours.

If you choose to have your child's physician complete the physical examination, **please indicate so below & return this form.** Any private physical exam performed after the commencement of the previous school year can be accepted as this year's physical. Please provide a copy of the exam to the school **within 30 days of entry** or an exam may be performed by the district per NYSED Commissioner's Regulation 136.3**.**

If you have any questions, please do not hesitate to call your child's school nurse.

Sincerely,

Mrs. Treat, RN
APW Elementary School
(315) 625-5203

Mrs. Krupke, RN
APW Jr/Sr High School
(315) 625-5223

Mrs. Bateman, LPN
APW Elementary School
(315) 625-5203

Mrs. Rossman, LPN
APW Jr/Sr High School
(315) 625-5223

_______ **I would like my child's physical done by his/her own doctor OR**
My child has already had a physical since the commencement of last school year & I will provide the results to the school nurse within 30 days of entry.

_______ **I would like to have my child's physical done at school**.

Student's Name ______________________________

Parent's Signature ______________________________ **Date** ______________

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STUDENT CONFIDENTIAL HEALTH FORM

Student Name:____**DOB:** __________________ **Grade:** _________
Last Name First MI

Address: _______________________________________ **Mailing (if different):**_______________________________
____ ___________________________________

Emergency Contact:

Parent/Guardian _____________________________ **Parent/Guardian:** ____
Phone: H _____________ **C** ____________ **W** ___________ **Phone: H** _____________ **C** ____________ **W** ____________

Alternate Contacts:
1.___________________________________**Relationship:** ______________ **Daytime Phone:** _______________
2.___________________________________**Relationship:** ______________ **Daytime Phone:** _______________

Please check below any conditions affecting your child which may affect his/her welfare in school:

- ☐ Drug Allergy
- ☐ Food Allergy
- ☐ Insect Allergy
- ☐ Environmental Allergy
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Asthma
- ☐ Arthritis
- ☐ Scarlet Fever
- ☐ Seizure Disorders
- ☐ Heart Condition
- ☐ Concussion
- ☐ Kidney Disease
- ☐ Vision Problems or Corrective lenses
- ☐ Recent Injuries
- ☐ Recent Surgeries
- ☐ Hearing Problems
- ☐ History of concussion
- ☐ If yes, how many?

List and explain any items checked above and any illnesses, injuries, or health problems the child has had in the past year or is currently being treated for:

List the medications with dosages your child takes on a regular basis; prescription and over the counter medications:

	Name of Drug	Dose and Frequency	Reason
1.			
2.			
3.			

My child wears: ☐ **Glasses** ☐ **Contacts** ☐ **Hearing Aid(s)** ☐ **Orthodontic Braces**
Other Brace: ☐ **Arm** ☐ **Leg** ☐ **Back**

Name of Healthcare Provider: ____________________________________ Phone: ___________________
Name of Dentist:____ Phone: ___________________

Permission for emergency medical treatment in case of injury or illness and parent/guardian is not available:

1. In an emergency, the information on this form may be given to emergency medical personnel. ☐ Yes ☐ No
2. I give permission for medical personnel to treat my child: ☐ Yes ☐ No
3. If my child must be hospitalized, my hospital preference is: ___________________________________
4. I give permission for my child to receive MD prescribed medication: ☐ Yes ☐ No

Parent/Guardian Signature: _______________________________________ **Date:** _______________________

Print Name of Parent/Guardian: ____