



**STUDENT INFORMATION FORM**

<b>First Name:</b>	<b>Middle Name:</b>	<b>Last Name:</b>	<b>Suffix:</b>
<b>Address: Street</b>		<b>City:</b>	<b>State &amp; Zip Code:</b>
<b>Social Security #:</b>	<b>Birth Date:</b>	<b>Age:</b>	
<b>Student Cell Phone #:</b>	<b>Home School District:</b>	<b>Home School:</b>	
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino  <b>Race (Choose all that apply, even if you answered Hispanic/Latino above):</b> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White			

**Parent/Guardian Information:**  Check here if same address as student

<b>First Name:</b>	<b>Middle Name:</b>	<b>Last Name:</b>
<b>Address: Street</b>	<b>City:</b>	<b>State &amp; Zip Code:</b>
<b>Primary Phone #/Type:</b> Mobile	<b>Alternate Phone #/Type:</b> Mobile	<b>Relationship:</b>
<b>Email Addresses:</b>		

**Parent/Guardian Information:**  Check here if same address as student

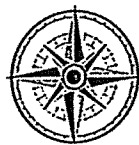
<b>First Name:</b>	<b>Middle Name:</b>	<b>Last Name:</b>
<b>Address: Street</b>	<b>City:</b>	<b>State &amp; Zip Code:</b>
<b>Primary Phone #/Type:</b> Mobile	<b>Alternate Phone #/Type:</b> Mobile	<b>Relationship:</b>
<b>Email Addresses:</b>		



**Emergency Contact Information (Other than parent/guardian listed above)**

**Note: In the event a student needs to be dismissed from school for an emergency, he or she will only be released to contacts listed. A photo ID will be required as well.**

<b>Emergency Contact Name:</b>	<b>Address Street: City, ST ZIP:</b>	<b>Phone # Primary: Alternate:</b>	<b>Relationship</b>
<b>Emergency Contact Name:</b>	<b>Address Street: City, ST ZIP:</b>	<b>Phone # Primary: Alternate:</b>	<b>Relationship</b>
<b>Emergency Contact Name:</b>	<b>Address Street: City, ST ZIP:</b>	<b>Phone # Primary: Alternate:</b>	<b>Relationship</b>
<b>Emergency Contact Name:</b>	<b>Address Street: City, ST ZIP:</b>	<b>Phone # Primary: Alternate:</b>	<b>Relationship</b>
<b>Emergency Contact Name:</b>	<b>Address Street: City, ST ZIP:</b>	<b>Phone # Primary: Alternate:</b>	<b>Relationship</b>
<b>Doctor's Name</b>	<b>Address</b>	<b>Phone #</b>	
<b>Dentist's Name</b>	<b>Address</b>	<b>Phone #</b>	



**ACKNOWLEDGEMENTS AND PERMISSIONS**

Student: \_\_\_\_\_

**PERSONAL PROPERTY WAIVER**

I understand that Connecticut Coastal Academy cannot be held responsible for any lost, borrowed, stolen or damaged belonging to the students at CTCA. We will, however, make reasonable attempts to rectify these situations. We encourage all students not to bring valuables into the school.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**EDUCATIONAL / ATHLETIC FIELD TRIP PERMISSION**

Transportation for these field trips will be provided by Connecticut Coastal Academy in CTCA vehicles. The signed permission will remain in effect until formal withdrawal occurs.

Permission IS GRANTED to attend Educational / Athletic Field Trips

Permission IS NOT GRANTED to attend Educational / Athletic Field Trips

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**VIDEOGRAPHY / PHOTOGRAPHY PERMISSION & WAIVER**

**Photography:**

At times, students are photographed for use in publications and our school website; social media accounts; and school marketing materials (e.g., CTCA informational brochure, press releases, local news article, etc.).

Photos that include my child CAN be used in publications

Photos that include my child MAY ONLY be displayed within the school setting / learning environment

Photos that include my child MAY NOT be used in any way

**Videography:**

At times, students are filmed for use on our school website and social media accounts; and as part of CTCA video/technology team projects; including original, in-school productions and student-filmed school activities.

Videos that include my child CAN be used in publications

Videos that include my child MAY ONLY be displayed within the school setting / learning environment

Videos that include my child MAY NOT be used in any way

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

*No student/family mailing addresses, email addresses or telephone numbers will ever be used in the aforementioned materials. Students may be identified by first and last name in local news stories, as is customary and meets general reporting standards.*



## Notice of Student Rights and Confidentiality

As a student of the CT Coastal Academy you should be informed of your rights. You are always entitled to be treated in a humane and dignified way, and with full respect to personal dignity, right to privacy, right to personal property and civil rights. You have the right to freedom from physical or mental abuse or harm; you have the right to a written treatment plan that is developed with your input and suited to your own personal needs, goals and aspirations (See CGS 17a-542). Other rights you have are as follows:

**Privacy & Confidentiality:** Health records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). The Family Educational Rights and Privacy Act (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all educational agencies and institutions that receive funds under any program administered by the Department of Education ("Department"). FERPA gives parents certain rights with respect to their children's education records at elementary and secondary schools that are subject to FERPA's requirements. These rights transfer to the student when he or she reaches the age of 18 or attends a postsecondary institution at any age ("eligible student"). The Family Educational Rights and Privacy Act (FERPA) prohibits a school from disclosing personally identifiable information from students' education records without the consent of a parent or eligible student, unless an exception to FERPA's general consent rule applies. In some emergency situations, schools may only need to disclose properly designated "directory information" on students that provide general contact information. In other scenarios, school officials may believe that a health or safety emergency exists and more specific information on students should be disclosed to appropriate parties. Understanding the options available under FERPA empowers school officials to act quickly and decisively when concerns arise. FERPA is not intended to be an obstacle in addressing emergencies and protecting the safety of students.

Under FERPA, a parent or eligible student must provide a signed and dated written consent before a school discloses personally identifiable information from the student's education records. 34 CFR § 99.30. See 34 CFR § 99.3 for the definition of "personally identifiable information." Exceptions to the general consent requirement are set forth in § 99.31 of the FERPA regulations. The term "education records" is defined as those records that are: (1) directly related to a student; and (2) maintained by an educational agency or institution, or by a party acting for the agency or institution. See 34 CFR § 99.3. Accordingly, all records, including immunization and other health records, as well as records on services provided to students under the Individuals with Disabilities Education Act (IDEA) and records on services and accommodations provided to students under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, that are directly related to a student and maintained by a school are "education records" under FERPA.

**Drugs and Alcohol Abuse Records:** In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (42 C.F.R. § 2.32)

**HIV Related Information:** In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)



**CONNECTICUT**  
COASTAL ACADEMY

**Access to Your Educational Record(s):** The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students." Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies. Parents or eligible students have the right to request that a school correct records which they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.

**Other Rights** may be guaranteed by state or federal statute, regulation or policies which have not been identified in this list. You are encouraged to seek counsel to learn more, or to better understand these laws and policies.

For more information about your rights in accordance with The Family Educational Rights and Privacy Act you may call 1-800-USA-LEARN (1-800-872-5327) or you may contact the Family Policy Compliance Office U.S. Department of Education, 400 Maryland Avenue, SW, Washington, D.C. 20202-8520

If you have any questions or concerns about this notice or your rights, or if you have a concern that your confidential information was not treated appropriately, please contact the Executive Director.

\*Client: I, \_\_\_\_\_ have received notice of my rights to confidentiality.

Date: \_\_\_\_\_

Parent/Guardian of Client: I, \_\_\_\_\_ have received notice of my child's rights to confidentiality.

Date: \_\_\_\_\_

\*CT Coastal Academy Staff: I, \_\_\_\_\_, have explained this notice to the client.

Date: \_\_\_\_\_

\* This form will be printed and reviewed with each student. At that time, the student and staff will date and sign.



### **Notification of Rights under FERPA for Elementary and Secondary Schools**

The Family Educational Rights and Privacy Act (FERPA) affords parents and students who are 18 years of age or older ("eligible students") certain rights with respect to the student's education records. These rights are:

1. The right to inspect and review the student's education records within 45 days after the day Connecticut Coastal Academy (CTCA) receives a request for access. Parents or eligible students should submit to the school principal a written request that identifies the records they wish to inspect. The school official will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.
2. The right to request the amendment of the student's education records that the parent or eligible student believes is inaccurate, misleading, or otherwise in violation of the student's privacy rights under FERPA. Parents or eligible students who wish to ask CTCA to amend a record should write the school principal, clearly identify the part of the record they want changed and specify why it should be changed. If the school decides not to amend the record as requested by the parent or eligible student, the school will notify the parent or eligible student of the decision and of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.
3. The right to provide written consent before the school discloses personally identifiable information (PII) from the student's education records, except to the extent that FERPA authorizes disclosure without consent. One exception, which permits disclosure without consent, is disclosure to school officials with legitimate educational interests. A school official is a person employed by the school as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel) or a person serving on the school board. A school official also may include a volunteer or contractor outside of the school who performs an institutional service of function for which the school would otherwise use its own employees and who is under the direct control of the school with respect to the use and maintenance of PII from education records, such as an attorney, auditor, medical consultant, or therapist; a parent or student volunteering to serve on an official committee, such as a disciplinary or grievance committee; or a parent, student, or other volunteer assisting another school official in performing his or her tasks. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility. Upon request, CTCA discloses education records without consent to officials of another school district in which a student seeks or intends to enroll or is already enrolled if the disclosure is for purposes of the student's enrollment or transfer. CTCA will make a reasonable attempt to notify the parent or student of the records request unless it states in its annual notification that it intends to forward records on request.
4. The right to file a complaint with the U.S. Department of Education concerning alleged failures by CTCA to comply with the requirements of FERPA. The name and address of the Office that administers FERPA are:

Family Policy Compliance Office  
U.S. Department of Education  
400 Maryland Avenue, SW  
Washington, DC 20202



**Family Educational Rights and Privacy Act (FERPA)  
Notice for Directory Information**

The *Family Educational Rights and Privacy Act* (FERPA), a Federal law, requires that CTCA with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, CTCA may disclose appropriately designated "directory information" without written consent, unless you have advised CTCA to the contrary in accordance with CTCA procedures. The primary purpose of directory information is to allow Connecticut Coastal Academy to include this type of information from your child's education records in certain school publications. Examples include:

- A playbill, showing your student's role in a drama production;
- The annual yearbook;
- Honor roll or other recognition lists;
- Graduation programs; and
- Sports activity sheets, such as for wrestling, showing weight and height of team members.

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. In addition, two federal laws require local educational agencies (LEAs) receiving assistance under the *Elementary and Secondary Education Act of 1965* (ESEA) to provide military recruiters, upon request, with the following information – names, addresses and telephone listings – unless parents have advised the LEA that they do not want their student's information disclosed without their prior written consent.<sup>1</sup>

If you do not want CTCA to disclose directory information from your child's education records without your prior written consent, you must notify CTCA in writing within 10 days of receipt of this notice. CTCA has designated the following information as directory information:

-Student's name  
-Address  
-Telephone listing  
-Electronic mail address  
-Photograph  
-Date and place of birth  
-Major field of study  
-Dates of attendance  
-Grade level

-Participation in officially recognized activities and sports  
-Weight and height of members of athletic teams  
-Degrees, honors, and awards received  
-The most recent educational agency or institution attended  
-Student ID number, user ID, or other unique personal identifier used to communicate in electronic systems that cannot be used to access education records without a PIN, password, etc. (A student's SSN, in whole or in part, cannot be used for this purpose.)

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<sup>1</sup> These laws are: Section 9528 of the Elementary and Secondary Education Act (20 U.S.C. § 7908) and 10 U.S.C. § 503(c).



**STUDENT MEDICAL UPDATE FORM**

Student: \_\_\_\_\_, Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Current Allergies (Medication, Environmental, Food):  
\_\_\_\_\_

Current medical and mental health conditions:  
\_\_\_\_\_

Parent/Guardian contacts:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mental Health Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please list any additional medical and/or mental health providers:

Name: \_\_\_\_\_ Type: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Type: \_\_\_\_\_ Phone #: \_\_\_\_\_

Current Medications (including over-the-counter, scheduled and as needed):

Medication	Dose (in milligrams)	When is it taken?

Will your child require any medications to be administered at school for this school year?  \*Yes  No

\*If you answered yes above, please have your child's physician complete the "Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel" form for each medication that will be administered at school. This includes daily medications, as needed medications (inhalers, allergy medication, etc.) and emergency medications (epi-pen, glucagon, etc.).

A few reminders about school medications:

- Forms and all medications need to be delivered to the school by parent or guardian. Students CANNOT deliver medications to school.
- A current, signed, medication authorization form is required for each medication that will need to be administered at school. Once signed and filed, consent forms are good for one year.
- Students are not allowed to carry medications during the school day except in rare situations that are approved by a doctor, with specific documentation on file with the school.
- The school will provide a reminder, either via phone or email, when approximately two weeks of school medication remains.
- Please know that we do not have full-time medical personnel on staff but all medical records and medication training are managed by a licensed nurse

Please contact us if you have additional questions or concerns.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date



School District: Connecticut Coastal Academy  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL**

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician assistant and, for interscholastic and intramural athletic events only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

**Prescriber's Authorization**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Condition for which drug is being administered: \_\_\_\_\_  
Name and Generic name of Drug: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Time of Administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_  
Relevant side effects: \_\_\_\_\_ None expected Specify: \_\_\_\_\_  
ALLERGIES: NO YES (specify): \_\_\_\_\_  
Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
(Month / Day / Year) (Month / Day / Year)

\*\*\*\*\*

Prescriber's Name/Title: \_\_\_\_\_  
Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_  
Address: \_\_\_\_\_  
Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

**PARENT/GUARDIAN AUTHORIZATION**

I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent's Home Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

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**SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL (Grades 6 -12)**

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board Policy. In the case of inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self administration:	Yes	No
_____	_____	_____
Signature		Date

Parent/Guardian authorization for self administration:	Yes	No
_____	_____	_____
Signature		Date

School nurse approval for self administration:	Yes	No
_____	_____	_____



# State of Connecticut Department of Education

## Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physi-

cian assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

*Please print*

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance?	Y N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance?	Y N	

\* If applicable

### Part 1 — To be completed by parent/guardian.

**Please answer these health history questions about your child before the physical examination.**

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
<b>Family History</b>						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take in school:

*All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school. <span style="float: right;">Signature of Parent/Guardian</span>	Date
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**To be maintained in the student's Cumulative School Health Record**

## Part 2 — Medical Evaluation

HAR-3 REV. 1/2022

### Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of Exam \_\_\_\_\_

I have reviewed the health history information provided in Part I of this form

### Physical Exam

Note: \*Mandated Screening/Test to be completed by provider under Connecticut State Law

\*Height \_\_\_\_\_ in. / \_\_\_\_\_ % \*Weight \_\_\_\_\_ lbs. / \_\_\_\_\_ % BMI \_\_\_\_\_ / \_\_\_\_\_ % Pulse \_\_\_\_\_ \*Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

### Screenings

*Vision Screening	*Auditory Screening	History of Lead level	Date
Type: <u>Right</u> <u>Left</u>	Type: <u>Right</u> <u>Left</u>	≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	
With glasses 20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Pass	*HCT/HGB:	
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*Speech (school entry only)	
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	Other:	

TB: High-risk group?  No  Yes PPD date read: \_\_\_\_\_ Results: \_\_\_\_\_ Treatment: \_\_\_\_\_

### \*IMMUNIZATIONS

Up to Date or  Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

#### \*Chronic Disease Assessment:

**Asthma**  No  Yes:  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise induced  
 If yes, please provide a copy of the **Asthma Action Plan** to School

**Anaphylaxis**  No  Yes:  Food  Insects  Latex  Unknown source

**Allergies** If yes, please provide a copy of the **Emergency Allergy Plan** to School

History of Anaphylaxis  No  Yes Epi Pen required  No  Yes

**Diabetes**  No  Yes:  Type I  Type II **Other Chronic Disease:** \_\_\_\_\_

**Seizures**  No  Yes, type: \_\_\_\_\_

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.  
 Explain: \_\_\_\_\_

Daily Medications (specify): \_\_\_\_\_

This student may:  participate fully in the school program  
 participate in the school program with the following restriction/adaptation: \_\_\_\_\_

This student may:  participate fully in athletic activities and competitive sports  
 participate in athletic activities and competitive sports with the following restriction/adaptation: \_\_\_\_\_

Yes  No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.  
 Is this the student's medical home?  Yes  No  I would like to discuss information in this report with the school nurse.

Signature of health care provider	MD / DO / APRN / PA	Date Signed	Printed/Stamped <b>Provider</b> Name and Phone Number
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**Part 3 — Oral Health Assessment/Screening**  
**Health Care Provider must complete and sign the oral health assessment.**

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

<b>Dental Examination</b> Completed by: <input type="checkbox"/> Dentist	<b>Visual Screening</b> Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	<b>Normal</b> <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	<b>Referral Made:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Risk Assessment</b> <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<b>Describe Risk Factors</b> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none; vertical-align: top;"> <input type="checkbox"/> Dental or orthodontic appliance  <input type="checkbox"/> Saliva  <input type="checkbox"/> Gingival condition  <input type="checkbox"/> Visible plaque  <input type="checkbox"/> Tooth demineralization  <input type="checkbox"/> Other _____                 </td> <td style="width:33%; border: none; vertical-align: top;"> <input type="checkbox"/> Carious lesions  <input type="checkbox"/> Restorations  <input type="checkbox"/> Pain  <input type="checkbox"/> Swelling  <input type="checkbox"/> Trauma  <input type="checkbox"/> Other _____                 </td> <td style="width:34%; border: none;"></td> </tr> </table>			<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____					

Recommendation(s) by health care provider: \_\_\_\_\_

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped <i>Provider</i> Name and Phone Number
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