



WASHINGTONVILLE CENTRAL SCHOOL DISTRICT

52 West Main Street, Washingtonville, New York 10992
PHONE 845.497.4000 • FAX 845.497.4030 • www.ws.k12.ny.us

Larry Washington, Ed.D., *Superintendent of Schools*
Barbara Quinn, *Assistant Superintendent for Curriculum and Instruction*
Lorine Van Put-Lamerand, *Assistant Superintendent for Business*
Michael Cogliano, Ed.D., *Assistant Superintendent for Pupil Personnel Services*
Paul Nienstadt, *Assistant Superintendent for Operations and Safety*
Lynn Imperato, *Director of Personnel and Staff Development*

HEALTH APPRAISAL INFORMED CONSENT AND HISTORY FOR SCHOOL EXAMINATION

Education Law, Section 903, and the Regulations of the Commissioner of Education require physical examinations of all children when they:

- Enter the school district for the first time
- Are in grades Pre-K or K, 1, 3, 5, 7, 9, 11
- Participate in interscholastic sports
- Need working papers
- Are referred to/by the Committee on Special Education

The Washingtonville Central School district recommends that all medical and dental examinations be conducted by your private physician for privacy and continuity of care. However, in some instances you may prefer to have the exam conducted in school. Please read the information below carefully and discuss the process and your decision with your child. Then please complete the permission form and the brief health questionnaire.

Though most parents do not attend examinations, you have a right to be present by prior arrangement with your school nurse. Your child will be asked age-appropriate psychosocial questions to assist the nurse practitioner in targeting health risks.

During the exam, every effort is made to preserve dignity and privacy, most health offices are too small to provide the level of privacy your child may be used to in his/her private provider's office. The exam includes a complete head-to-toe screening of all major organ systems, INCLUDING breast/pubic area for girls and hernia/penis/testicles/pubic area for boys if needed, along with a femoral pulse exam for both genders. The examiner will touch your child. There is every attempt to have an additional person as a chaperone during this part of the examination.

PLEASE ANSWER THE QUESTIONS ON THE NEXT PAGE AND SIGN YOUR CONSENT. AN EXAMINATION WILL NOT BE DONE IN SCHOOL WITHOUT YOUR SIGNED CONSENT. DELAYS IN RETURNING PERMISSION COULD RESULT IN A DELAY IN YOUR CHILD'S CLEARANCE FOR EXTRACURRICULAR ACTIVITIES INCLUDING SPORTS.

The Washingtonville Central School District is committed to the intellectual, cultural, physical and emotional growth of our children in a safe and supportive environment.



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Parent Permission for a School Examination: Please return to SCHOOL NURSE

Student's Name _____ Grade _____ DOB _____

My child had a health appraisal done by Dr. _____ on _____. I will provide the District with the Health Appraisal form filled out by the doctor.

My child has an appointment to have a health examination done by Dr. _____ on _____. I will provide the District with the Health Appraisal form filled out by the doctor.

I give permission to have my child interviewed and examined by the school Nurse Practitioner scheduled at the convenience of the school. I attest I have read the attached information on health appraisals and have advised my child of my decision.

Please answer the following questions. Circle or X the correct answer:

- Had any serious injuries, illness or operations? NO YES
- Had any dizziness, fainting, or chest pain while exercising? NO YES
- Had asthma or other breathing problems? NO YES
- Had any heart problems or high blood pressure? NO YES
- Had a bleeding disorder? NO YES
- Had a liver or spleen problem? NO YES
- Had kidney disease or absence of one kidney? NO YES
- Had any muscle, joint or bone problems, including fractures? NO YES
- Been knocked unconscious, or had a concussion? NO YES
- Had seizures?NO YES If yes, are they well controlled? NO YES
- Does your child have any current skin problems, sores, or rashes? NO YES
- Are there any life-threatening allergies? NO YES
- Does your child have any other life-threatening condition? NO YES
- Is the student currently taking any medications? NO YES
- Are medications needed for the sport? NO YES Will child carry medicine? NO YES
- Does your child have absence of vision in one eye or loss of an eye? NO YES
- Does your child wear glasses or contact lenses? NO YES
- Does your child have hearing impairment in one both ears? NO YES
- Does your child wear orthodontic equipment (braces, retainer, etc.)? NO YES
- Are you aware of any medical or physical restrictions which might disqualify or limit your child's full participation in any of our athletic programs? NO YES
- MALES: Had a hernia, undescended testicle or absence of one testicle? NO YES
- FEMALES: Are there any problems regarding menstruation? NO YES Age menstruation began _____

Parent Signature _____

Print Parent Name _____

Date _____