GREAT NECK PUBLIC SCHOOLS
Health Services
Physical – Dental Exam Requirements

Dear Parent /Guardian of Incoming 7th Grader: 2024-2025

The State Education Law – Section 903 – requires a physical examination of children when they enter and re-enter school, and in Grades: Pre-K, K, 1,3,5,7, 9 and 11.

New York State guidelines state that physical examinations are good for one (1) year from the date of exam. Therefore, if your child has had a recent physical, please forward this examination to the health office at your child's school. A New York State physician, nurse practitioner or physician's assistant must sign and stamp each examination.

The New York State Mandated Requirements are as follows:

PHYSICAL EXAMS:

- **For NEW ENTRANT to the school district, this Physical examination must be submitted within 30 days after entering school.**
- **For students in GRADES: Pre-K, K, 1, 3, 5, 7, 9, 11 a physical examination must be submitted within 30 days of the first day of school.**
- **Students in GRADES 7-12 playing Interscholastic Sports require an Annual Physical Exam including the Family Cardiac History review noted. (Dominick Murray Sudden Cardiac Arrest Prevention Act)**
- **All examinations must include: a BMI and Weight Status Category, and information regarding Asthma, Diabetes Type 1 & Type 2, Hyperlipidemia & Hypertension.**
- **Dental exams are requested in GRADES: Pre-K, K, 1, 3, 5, 7, 9 and 11**

Attached are medical and dental forms for your use, which are to be completed by your family Health Care Provider and Dentist and returned to the health office in your child's school. Forms are also available on the GNPS Website—>Parents section—>GNPS Forms.

**** ONLY THE CURRENT NYS SCHOOL HEALTH EXAMINATION FORM WILL BE ACCEPTED (Revision: 5/2023)**

Your prompt attention to this matter is greatly appreciated,

Marianne Roofeh, RN
Phone: (516) 441-4610
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GREAT NECK PUBLIC SCHOOLS
Health Services
Meningitis Vaccine Requirements

Dear Parent/Guardian of Incoming 7th graders, 2024-2025

Children entering or **attending 7th** and 12th grade on or after September 1st 2016, must receive an adequate dose of **MENINGOCOCCAL VACCINE (MenACWY, Menactra).** All 7th grade students must have this vaccine.

You are receiving this notice because your child has NOT received this vaccine.

Please contact your child's physician to ensure that he/she has received or is scheduled to receive the appropriate dose of the meningitis vaccine **prior to the start of the new school year.**

Written proof from your HEALTH CARE PROVIDER- MD/PA/NP indicating the date of injection and Provider signature and stamp must be provided to the school nurse.

If you have any questions, please call the Health Office.

Marianne Roofeh, RN
Phone: 516-441-4610
Fax: 516-441-4695
Email: mroofeh@greatneck.k12.ny.us

Please have your physician fill out this form and return to the Health Office.
DUE DATE: SEPTEMBER 16, 2024

Student Name: _____

Date of Meningitis Vaccine: _____

_____
Physician's Signature and Stamp
Address and Phone Number

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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 Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*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.

GREAT NECK PUBLIC SCHOOLS
Health Services
Dental Health Report

Date_____

Teacher's Name ******Grade 7_____

This is to certify that _____

_____Is under my care for dental treatment

_____Has completed dental treatment

_____
Signature of Dentist

_____
Address

- This report should be returned to the school nurse.

GREAT NECK PUBLIC SCHOOLS
Health Services
Confidential Health Concerns

Date _____

Name _____

Grade 7 Teacher _____

Dear Parent:

For the safety and well being of your child, it is important that the appropriate staff be aware of any health concerns your child may have.

By signing this form you are authorizing the nurse to share this important information with relevant school staff.

Medication Allergy:

Food Allergy: Does your child require placement at the "Nut Free Table"? (Please circle): YES NO

Other Allergy: (i.e. insect bites, bee stings, etc.)

Medication:
*If your child requires medication {i.e. Epi-Pen} for Life Threatening Allergies, for the safety of your child, immediately contact your school nurse for further directions

Medical Concerns:

Treatment:

****Your prompt return, of this vital form, is greatly appreciated.****

Marianne Roofeh, RN
Mroofeh@greatneck.k12.ny.us
School Nurse
Health Services
Phone: 516-441-4610
Fax: 516-441-4695

_____
*Parent Signature