Red Creek Central School
2025-2026 Emergency & Health Information

Please return to NURSE'S OFFICE as soon as possible
Please fill out form completely (FRONT & BACK). Leave no space blank. Thank you.

Student Information:

Grade _____

Student's Name _____ Home Phone ( ) _____-_____
Last First M.I.

Address _____ Mailing if different _____
Street Town/State Zip

Family Doctor_____ Phone Number ( ) _____-_____

All persons living in the home (name, age, relationship) _____
_____

Is there a custody order in place? Yes____ or No____ (If yes a copy MUST be provided)

1st Parent/Guardian contact: Ok to pick up? Yes____ No____

Name _____ Relationship _____
Last First M.I.

Address _____ Mailing if different _____
Street Town/State Zip

Home ( ) _____-_____ Cell ( ) _____-_____ Work ( ) _____-_____ Work Place_____

2nd Parent/Guardian contact: Ok to pick up? Yes____ No____

Name _____ Relationship _____
Last First M.I.

Address _____ Mailing if different _____
Street Town/State Zip

Home ( ) _____-_____ Cell ( ) _____-_____ Work ( ) _____-_____ Work Place_____

Emergency Contact Information: (Other than parent / legal guardian)
If I am unavailable to pick-up my child and you have unsuccessfully tried to reach me, the following have permission to pick-up my child *(we will try both parents first unless you notify us differently)*.

Name _____ Relationship _____ Home ( ) _____-_____
Address _____ Cell ( ) _____-_____ Work ( ) _____-_____

Name _____ Relationship _____ Home ( ) _____-_____
Address _____ Cell ( ) _____-_____ Work ( ) _____-_____

Additional names may be added on a separate sheet. You may also add or delete any emergency contacts during the school year by notifying the school in writing.

_____ _____
Signature of Parent / Guardian **Date**

CONFIDENTIAL

Emergency Medical Information:

Please list any health condition which the school nurse should be aware of:

_____
_____
_____

Bee stings / Food allergies: Doctor / hospital confirmed allergy? Yes _____ No _____

If yes, what is your child allergic to?

_____

Does your child need to take medication for this allergy? Yes _____ No_____

If yes, what medication does your child take?

_____

Is this medication to be kept in school? Yes _____ No _____

Allergies: _____
_____
_____

Diet Restrictions: _____
_____
_____

Medication student is taking: _____
_____

Hospital preferred: _____

This information may be shared with any necessary staff members.

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Grade _____

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Address _____ Mailing if different _____
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Family Doctor_____ Phone Number ( ) _____-_____

All persons living in the home (name, age, relationship) _____
_____

Is there a custody order in place? Yes_____ or No _____ (If yes a copy MUST be provided)

1st Parent/Guardian contact: Ok to pick up? Yes _____ No_____
Name _____ Relationship _____
Last First M.I.
Address _____ Mailing if different _____
Street Town/State Zip
Home ( ) _____-_____ Cell ( ) _____-_____ Work ( ) _____-_____ Work Place_____

2nd Parent/Guardian contact: Ok to pick up? Yes _____ No_____
Name _____ Relationship _____
Last First M.I.
Address _____ Mailing if different _____
Street Town/State Zip
Home ( ) _____-_____ Cell ( ) _____-_____ Work ( ) _____-_____ Work Place_____

Emergency Contact Information: (Other than parent / legal guardian)
If I am unavailable to pick-up my child and you have unsuccessfully tried to reach me, the following have permission to pick-up my child *(we will try both parents first unless you notify us differently)*.

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Address _____ Cell ( ) _____-_____ Work ( ) _____-_____

Name _____ Relationship _____ Home ( ) _____-_____
Address _____ Cell ( ) _____-_____ Work ( ) _____-_____

Additional names may be added on a separate sheet. You may also add or delete any emergency contacts during the school year by notifying the school in writing.

_____ _____
Signature of Parent / Guardian **Date**

RED CREEK CENTRAL SCHOOL DISTRICT

2025-2026 CONFIDENTIAL HEALTH INFORMATION

IMPORTANT: PLEASE COMPLETE AND RETURN TO THE NURSE'S OFFICE ASAP, EVEN IF NOTHING HAS CHANGED. THIS INFORMATION HELPS US TO CARE FOR YOUR CHILD IN THE BEST POSSIBLE MANNER.

Student Name _____ Grade _____

Family Doctor Name & Phone No. _____

Emergency Medical Information - Please tell us about any health condition that your child is experiencing:

_____

_____

_____

_____

_____

_____

_____

_____

Bee stings/Food allergies: Doctor/hospital confirmed allergy? Yes _____ No _____

Does your child need to take medication for this allergy? Yes_____ No _____

Is this medication to be kept in school? Yes _____ No _____

List all allergies/health conditions and needed medications:

Medication	**Allergy/Health Condition**

Diet Restrictions: _____

_____

_____

Hospital preferred: _____

This information may be shared with any necessary staff members.

NEW ENTRANT HEALTH INFORMATION

Student's name:_____ Grade:_____

Does your child have any of the following conditions? Please check yes or no:

	YES	NO
Vision	_____	_____
Hearing	_____	_____
Asthma/Breathing problems	_____	_____
Allergies	_____	_____
Speech difficulties	_____	_____
Bleeding problems	_____	_____
Seizures or other nerve problems	_____	_____
Kidney problems	_____	_____
Heart problems	_____	_____
Diabetes	_____	_____
Eating problems	_____	_____
Any other problems	_____	_____

If you checked yes to any of the above please briefly explain:_____

_____

Are there any instructions? _____

Is your child taking any medication? _____yes _____no

If yes, please list: _____

Name of doctor: _____Phone:_____

Name of dentist:_____Phone:_____

I am aware that this information will be shared with any necessary staff.

Parent/Guardian signature:_____Date:_____

Please return as soon as possible to the Middle School-High School nurse's office, if you have any questions please call Kristy Smith RN at 754-2156 Thank you.

Parent Notification/Request For Mandated Health Appraisal

Dear Parent(s) or Guardian(s):

New York State law requires that each child in a school district have a health examination including body mass index before entering school for the first time, and again in grades 1, 3, 5, 7, 9, 11. Students wishing to play interscholastic sports or requesting work permits must have an annual health exam. A dental exam form is also requested, but not required at these same times.

Your own health care provider is always the best choice for these exams. We encourage you to call early as it may take several weeks to schedule exams during the busy summer and fall months.

We have included a form for your health provider to complete. You or your provider may return the completed form to the school health office. Our fax number is 315-754-2157.

If you do not provide an exam form, an exam will be scheduled with our school medical director. While most parents choose not to attend, you may do so if you wish. Please let your child know they will be examined at school. We will notify you prior to the exam being done.

Upon completion of in-school exams, you will be informed of any important findings and need to follow up with your health care provider.

Please Complete and Return the Bottom Portion to Your Building Health Office Today

.....✂.....

Student's Name _____ **Grade** _____

Student's School _____

☐ My child had a health exam on _____. I will return the completed form by the date above.

☐ My child has an appointment to have a physical with his/her health care provider on _____. My child's MD/NP/PA or I will return the form by the date above.

☐ I need information on obtaining health insurance or finding a health care provider.

☐ Schedule the district physician/nurse practitioner to complete the exam for my child.

Parent Name _____ Date_____

Parent's Signature _____

Parent Phone Contact ( ) _____

School Nurse: Gloria Parsnow, RN School: Red Creek MS/HS

Email: Gloria.parsnow@rccsd.org

Phone: 315-754-2158 Fax 315-754-2157

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.

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. 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.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment ? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ 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 preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ on_____ (date of assessment)
The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

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 this information to your child's school, 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.

RED CREEK CENTRAL SCHOOL DISTRICT

MARGARET W. CUYLER ELEMENTARY SCHOOL, P.O. BOX 190, RED CREEK, NEW YORK 13143

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's health care

provider(s) listed below to release my child's _____
medical records to the district's medical officer, physical (PT), occupational (OT), psychologist or school nurse.

Dr. Name: _____ Phone _____
Address: _____

Dr. Name: _____ Phone _____
Address: _____

The Healthcare provider may disclose the following protected health information

- o Immunizations
- o Health Appraisals
- o Past/current medical conditions and impact on attendance, school programming, and/or
- o OT,PT or ST needs

The protected Health Information may be used, disclosed or received for the following purposes

- o To develop care or therapy for school management/ design educational programs
- o To assess the medical impact of medical conditions on school programming
- o To share school observations/concerns surrounding behaviors
- o To assess a medical basis fro modifications of transportation and/or home tutoring
- o Medication delivery and/or therapy prescriptions for OT/PT/ST
- o At patient's request with no specific purpose
- o Other _____

Please select one:

- o This authorization is valid for the child's entire school career
- o This authorization shall expire on _____/_____/_____

I acknowledge that I have a right to revoke this authorization at any time by sending written notice to the Privacy Officer at my healthcare provider's office and to the District's Administrative Building. I understand that the revocation of this authorization in not effective if the Healthcare provider has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Healthcare information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclose and may no longer be protected by federal or state laws. I understand that my child's treatment in not dependent on my agreement to release or withhold information.

Date Signature of Patient (over 18), Parent or Guardian

You May Refuse to Sign This Authorization