Olean City School District Student Health History

Name of Student: _____

Student's Physician:_____ **Phone #:**_____

HAS STUDENT HAD?	Y / N	IF SO, WHEN?	HAS STUDENT HAD?	Y / N	IF SO, WHEN?
ADD/ADHD			Measles		
Allergies			Mental Illness		
Anemia			Migraines		
Asthma			Mononucleosis		
Chicken Pox			Mumps		
Contact with TB			Operations		
Diabetes			Pneumonia		
Diphtheria			Polio		
East Conditions			Rheumatic Fever		
Epilepsy			Scarlet Fever		
Fainting Spells			Seizures		
Frequent Colds			Serious Injury		
German Measles			Sore Throats		
Heart Disease			Tonsillectomy		
Heart Murmur			Tuberculosis		
Hepatitis			Whooping Cough		
High Blood Pressure					

MEDICATIONS

Is student taking any medications? Yes_____ No_____

Will medications be administered by nurse during school hours? Yes_____ No_____

Please list the medications:_____

ALLERGIES? If yes, how do they present?

Bee Stings_____

Food_____

Medication_____

Other_____

CHRONIC HEALTH CONDITIONS *If yes, please list*

Does student have any chronic health conditions? *Yes*_____ *No*_____

(Such as diabetes, heart conditions. kidney disease, musculoskeletal conditions, etc)***?***

*Please list along with special care required for condition:*_____

_____

HOSPITALIZATIONS

Has student ever been hospitalized for illness, injury, or surgery? Yes_____ No_____

Please list: _____

EMERGENCY ROOM VISITS-

Has student ever been treated in the emergency room (if different from hospitalizations)? Yes___ No___

*Please list*_____

Does student have any vision problems? Yes_____ No_____ _____

Does student wear glasses or contacts? Yes_____ No_____ _____

Does student have any hearing problems? Yes_____ No_____ _____

Are immunizations up to date (Required for entrance to school)? Yes_____ No_____

Is there any other information you would like the school nurse to know about this student or the student's family?

_____

Signature_____

Relationship_____

Date_____

Olean City School District Student Registration Packet

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 opn 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.

Olean City School District
410 West Sullivan Street
Olean, New York 14760

Authorization for Medical Treatment

To Whom It May Concern:

We/I _____

Residing at: _____

_____

In the event that I cannot be reached, I do hereby authorize designated agents (building principals and /or school nurses) of the Olean City School District Board of Education, Olean, NY 14760, *to admit and authorize any hospital or medical/physician services* be rendered to my child or legal ward named: _____

Major surgery would be authorized only if the medical opinion of two (2) licensed physicians or dentists concur the necessity of such surgery.

I understand that the siblings of this child listed below are not covered on this medical release:

Name: _____ Age: _____

Name: _____ Age: _____

This authorization is to be effective from the date the child enters school until the child graduates. It is the parent's responsibility to contact the school with any changes to this form as they occur.

Physician		Allergies	
Dentist		Last Tetanus Shot	
Other Medical Specialists		Religion	
Other health concerns			

SWORN To BEFORE ME ON:
_____/_____/20_____

_____
Notary Public

Please sign in front of a notary or the Central Registrar who is a notary. Picture ID required.

Signed: _____
Parent or Legal Guardian