Kevin Miller, Ed.D.
Kmiller3@sachem.edu

Superintendent of Schools
Patti Trombetta

51 School Street
Lake Ronkonkoma,
NY 11779
631.471.7861
ext. 1145

#WeAreSachem

Sachem Central School District

Central Registration

Documents Required at the Time of Registration

Original Birth Certificate with a raised seal

Parent or Guardian's photo identification
The residential parent or guardian of the child must be in attendance at the time of registration. If you are a step-parent, please bring your marriage certificate with you. It is not necessary for your child to be with you at the time of registration.

Proof of Residency from Parent/Guardian (all must provide first and second proof):

First Proof

1. **Homeowners, Proof of Ownership**
   a. Current mortgage statement or
   b. Current yearly property tax bill or
   c. Indenture documents if registering within 90 days of closing
2. **Renters in an Apartment Complex**
   a. Original lease must be signed by both the parent/guardian and complex management. The lease must be current. Registration cannot take place prior to the move in date.
3. **Renting or Living in a Private Home that you do not own**
   a. Residents living in a privately owned home that he/she does not own must submit a Statement of Residence. The affidavit must have both the homeowner's and the parent/guardian's signatures. The homeowner must also provide the current month's mortgage statement or current year's tax bill. Registration cannot take place prior to the move in date. The Affidavit of Residence form is available on the Sachem website as well as at the Central Registration Office.

Second Proof- Must be in the parent/guardian's name

1. Utility bill (electric, gas, cable, house telephone or water) or car insurance document dated within 30 days of registration.
2. If the above is not possible, three separate documents addressed to the residence are required. They must be dated within 30 days of registration. Examples of such are payroll stub, health insurance statement, cell phone bill, governmental agency letter, bank statement, medical bill, etc.

Immunization as mandated by the New York State Department of Health.
Proof of required **immunizations** for school entry is mandated by the New York State Department of Health and must be presented at the time of registration. Current immunization requirements can be provided at the Central Registration Office or found at http://www.health.ny.gov/publications/2370.pdf. The child's immunization booklet is not acceptable. Proof must be on physician's letterhead and signed by either actual signature, electronic signature, or signature stamp.

Health Examination as mandated by the New York State Department of Health
All new entrants must have a **Health Examination**. The physical examination form will be accepted if it is dated not more than twelve months prior to the student's first day of attendance. If this documentation cannot be presented at the time of registration, it must be provided to the school within 30 days of the student's first day of attendance. The student may receive a physical examination from the school physician if the documentation is not received. A Dental Health Certificate is suggested but not required for registration. Both dental and physical forms can be provided at the Central Registration Office or on the Sachem website, https://sachem.edu/Assets/Health_Services_Documents/040423_NYS_Health_Examination_Form-All.pdf?t=638161947161300000
If your child receives Special Ed or Related Services, you must supply the IEP at the time of registration.

Custody Issues (if applicable) – Please supply any court documents regarding custody

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Sachem Central School District

Central Registration

Documentos requeridos al momento de registro

Acta de Nacimiento original con sello en relieve

Identificación con fotografía de los padres o tutores
El padre o tutor residencial del niño debe estar presente en el momento de la inscripción. Si es padrastro o madrastra, traiga su certificado de matrimonio. No es necesario que su hijo esté con usted en el momento de la inscripción.

Prueba de residencia del padre/tutor (todos deben proporcionar primera y segunda prueba):

Primera prueba

1. **Propietarios, Prueba de propiedad**
   a. Estado de cuenta actual de la hipoteca o
   b. Factura anual actual de impuestos a la propiedad o
   c. Documentos de contrato si se registra dentro de los 90 días posteriores al cierre
2. **Renters in an Apartment Complex**
   a. El contrato de arrendamiento original debe estar firmado por el padre/tutor y la administración del complejo. El contrato de arrendamiento debe estar al día. El registro no puede realizarse antes de la fecha de mudanza.
3. **Alquilar o vivir en una casa privada que no es de su propiedad**
   a. Los residentes que vivan en una casa privada que no sea de su propiedad deben presentar una Declaración de residencia. La declaración jurada debe tener la firma del propietario y del padre/tutor. El propietario también debe proporcionar el estado de cuenta de la hipoteca del mes actual o la factura de impuestos del año en curso. El formulario de declaración jurada de residencia está disponible en el sitio web de Sachem, así como en la oficina central de registro.

Segunda prueba- Debe estar a nombre del padre/tutor

1. Factura de servicios públicos (electricidad, gas, cable, teléfono de la casa o agua) o documento de seguro de automóvil con fecha dentro de los 30 días posteriores al registro.
2. Si lo anterior no es posible, se requieren tres documentos separados dirigidos a la residencia. Deben estar fechados dentro de los 30 días posteriores al registro. Ejemplos de tales son talón de nómina, declaración de seguro médico, factura de teléfono celular, carta de agencia gubernamental, extracto bancario, factura médica, etc.

Vacunación según lo dispuesto por el Departamento de Salud del Estado de Nueva York.
El Departamento de Salud del Estado de Nueva York exige la prueba de las vacunas requeridas para ingresar a la escuela y se debe presentar en el momento de la inscripción. Los requisitos de vacunación actuales se pueden proporcionar en la oficina de registro central o se pueden encontrar en http://www.health.ny.gov/publications/2370.pdf. El folleto de vacunación del niño no es aceptable. La prueba debe estar en papel con membrete de médico y estar firmada con una firma real, una firma electrónica o un sello de firma.

Examen de salud según lo dispuesto por el Departamento de Salud del Estado de Nueva York
Todos los nuevos ingresantes deben tener un examen de salud. Se aceptará el formulario de examen físico si tiene una fecha de no más de doce meses antes del primer día de asistencia del estudiante. Si esta documentación no se puede presentar en el momento de inscripción, se debe proporcionar a la escuela dentro de los 30 días posteriores al primer día de asistencia del estudiante. El estudiante puede recibir un examen físico del médico de la escuela si no se recibe la documentación. Se sugiere un certificado de salud dental, pero no se requiere para el registro. Tantos los formularios dentales como los físicos se pueden proporcionar en la oficina central de registro o en el sitio web de Sachem, https://sachem.edu/Assets/Health_Services_Documents/040423_NYS_Health_Examination_Form-All.pdf?t=638161947161300000

Si su hijo recibe educación especial o servicios relacionados, debe proporcionar el IEP en el momento de la inscripción.
Cuestiones de custodia (si es aplicable) – Proporcione todos los documentos judiciales

SACHEM CENTRAL SCHOOL DISTRICT

Patti Trombetta
Superintendent of Schools

Kevin Miller
Attendance Teacher

Central Registration
51 School Street
Lake Ronkonkoma, NY 11779
(631) 471-7861

Request for Student Records

Date: _____ Student's Name _____

Date of Birth _____ Current/Entering Grade_____

The above listed student has enrolled in the Sachem Central School District on _____. Please send all applicable records pertaining to this student to the school indicated below. Thank you.

- Immunization Records/Current Physical/Health Records
- Standardized Test Data/NYS Assessments
- Attendance Record
- Withdrawal Grades
- Most Recent Report Card
- Science Labs
- Transcript
- NYSESLAT Scores
- IEP(Individualized Education Plan); if applicable
- Most Recent Special Education Evaluations; if applicable

Cayuga Elementary School 865 Hawkins Avenue Lake Grove, NY 11755 (631)471-1800	**Chippewa Elementary School** 31 Morris Avenue Holtsville, NY 11742 (631)696-8640	**Grundy Elementary School** 950 Grundy Avenue Holbrook, NY 11741 (631)471-1820	**Hiawatha Elementary School** 97 Patchogue-Holbrook Road Lake Ronkonkoma, NY 11779 (631)471-1830
Lynwood Elementary School 50 Lynwood Avenue Farmingville, NY 11738 (631)696-8650	**Merrimac Elementary School** 1090 Broadway Avenue Holbrook, NY 11741 (631)244-5670	**Nokomis Elementary School** 151 Holbrook Road Holbrook, NY 11741 (631)471-1840	**Tamarac Elementary School** 50 Spence Avenue Holtsville, NY 11742 (631)244-5680
Waverly Avenue Elementary 1111 Waverly Avenue Holtsville, NY 11742 (631)654-8690	**Wenonah Elementary School** 251 Hudson Avenue Lake Grove, NY 11755 (631)471-1880	**Sagamore** 57 Division Street Holtsville, NY 11742 (631)696-8600	**Samoset** 51 School Street Lake Ronkonkoma, NY 11779 (631)471-1700
Seneca 850 Main Street Holbrook, NY 11741 (631)471-1850	**Sachem High School East** 177 Granny Road Farmingville, NY 11738 (631)716-8200	**Sachem High School North** 212 Smith Road Lake Ronkonkoma, NY 11779 (631)471-1400	**Sachem CSD-OISA Home Schooling** 51 School Street, Rm. 203 Lake Ronkonkoma, NY 11779 (631)471-1348

_____ _____

Parent or Guardian Signature Date School Personnel Signature

STUDENT NAME _____

DATE OF BIRTH_____

HEALTH HISTORY – PAGE 1

If your child has had any of the following, please describe and include the dates:

Allergies:

Environmental _____

Food _____

Medication _____

Anemia _____

Sickle Cell _____

Sickle Cell Trait _____

Asthma/Medication Used _____

Cancer _____

Cystic Fibrosis _____

Diabetes/Medication Used _____

Insulin Dependent _____

Heart Disease _____

Heart Surgery _____

Hearing Loss _____

Loss _____ r _____ l _____

Has your child received services for this hearing problem? _____

Chronic Ear Problems _____

Hemophilia/Bleeding Disorders _____

Gastrointestinal Disease _____

Hospitalizations/Operations _____ Reason _____

_____

Vision Problem _____

Loss _____r _____l _____

Has your child received services for this vision problem? _____

STUDENT NAME _____

DATE OF BIRTH_____

HEALTH HISTORY – PAGE 2

Scoliosis _____

Head Injury _____

Concussion _____ Other _____

Serious Injuries _____

_____

Seizure Disorders

Grand Mal _____

Petit Mal _____

Focal _____

Other _____

Illnesses (please circle):

Chicken Pox – Doctor's verification is needed Measles Mumps German Measles

Rheumatic Fever Pertussis

Is there anything concerning your child's health that the school should know in order to provide special care?

Yes _____ No _____

If yes, please explain: _____

_____

Please be advised that a yearly examination by your family physician is advisable. Physical examinations are *required* for all *new entrants* and must be dated within 12 months of the date your child enters school.

Physicals are also mandated for students entering Pre-K, Kindergarten, grades 1, 3, 5, 7, 9 and 11. Again, the physical must be dated within 12 months.

These examinations are performed for the purpose of detecting problems in their early stages with the hope of directing attention to them for proper medical treatment.

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

TO BE COMPLETED BY SCHOOL PERSONNEL

Country of birth: _____

Date of student's initial entry to US:
Month_____ Day_____ Year _____

Country from which student emigrated: _____

Number of years attended school outside of the U.S.: ___

Schools attended outside of the U.S.: _____

Number of years attended school within the U.S. (including pre-school): _____

Date the student entered U.S. schools:
Month_____ Day_____ Year _____

English speaking contact: _____
Phone # _____

If translator needed, preferred language: _____

Home Language Questionnaire (HLQ)

Please write clearly when completing this section.

STUDENT NAME:		
First	*Middle*	*Last*

DATE OF BIRTH:			GENDER:
			❑ Male ❑ Female
Month	*Day*	*Year*	

PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to Student*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other _____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

HOUSING QUESTIONNAIRE

Name of School: _____

Name of Student: _____
Last First Middle

Gender: Male _____ Female _____ Date of Birth _____/_____/_____ Grade: _____

Address: _____ Phone _____

_____

The answer you give below may help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act may also be entitled to transportation and other services.

Where is the student currently living? (Please check **one**)

_____ In Permanent Housing (house, apartment, trailer)

_____ In a Shelter

_____ With Another Family because of loss of housing or as a result of economic hardship

_____ In a Hotel/Motel

_____ In a Car, Park, Bus, Train or Campsite

_____ Other (please describe) _____

_____ _____

Print Name of Parent, Guardian
(or Student if Unaccompanied Youth)

Signature of Parent, Guardian
(or Student if Unaccompanied Youth)

_____
Date

If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

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:**

LaboratoryTesting	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.**

<u>If Restrictions Apply</u> – 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 <u>ONLY</u> 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.

Sachem Central School District

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

FAMILY HEART HEALTH HISTORY

A relative has/had any of the following:

Check all that apply:

☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
☐ Heart rhythm problems, long or short QT interval?
☐ Brugada Syndrome?
☐ Catecholaminergic Ventricular Tachycardia?
☐ Marfan Syndrome (aortic rupture)?
☐ Heart attack at age 50 or younger?
☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

☐ Known heart abnormalities or sudden death before age 50? ☐ Structural heart abnormality, repaired or unrepaired?
☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

Name:	Affirmed Name (if applicable):	DOB:

If you answered **YES** to any questions give details. Sign and date below**.**	
Parent/Guardian Signature:	Date:

Is there any condition that would prevent your child from participating in physical education?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

Parent/Guardian Signature: _____ Date: _____

SACHEM CENTRAL SCHOOL DISTRICT

Dental Health Certificate

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.