



📌 Important Health Requirements for the 2025–26 School Year

Dear Parents/Guardians,

To ensure a healthy and safe school year, **students must meet certain health and immunization requirements** before starting school in Fall 2025.

📄 Health Exams (Physicals) & Immunizations Are Required For: Students entering Grades K, 1, 3, 5, 7, 9, and 11 All new students to the district (regardless of grade level)

📄 Submit completed forms:

Grades K–5: Email to Higginsf@tuckahoeschools.org

Grades 6–12: Email to Devereuxj@tuckahoeschools.org

📄 Download all required forms from:

https://www.tuckahoeschools.org/school_nurse_information

📌 Required Immunizations by Grade Level

Grades K–5:

DTaP: 5 doses (or 4 if 4th dose was given after age 4)

Polio (IPV/OPV): 4 doses (or 3 if 3rd was after age 4)

MMR (Measles, Mumps, Rubella): 2 doses

Varicella (Chickenpox): 2 doses

Hepatitis B: 3 doses

Grade 6:

Tdap: 1 dose (Required between ages 10–11)

Grade 7:

Meningococcal: 1st dose (Required after age 10)

Grade 12:

Meningococcal: 2nd dose

(Not needed if 1st dose was after age 16)

📄 Deadline: Proof of all vaccinations must be submitted **within 14 days of school starting** to comply with New York State health regulations.

📄 Medical Care Plans (If Applicable):

If your child has any of the following or any chronic condition, submit the proper care plan (found on the school website) or a comparable form filled out by your doctor: **Food allergies, Asthma, Seizures, Diabetes etc.**

OTC/Prescription Medication Authorization Form if your child needs medication at school. Medications are to be delivered to the school by an adult and handed off to an adult (nurse, security, TA, teacher) No students are to bring medication to school.

Feel free to reach out to the school nurse with any questions. Thank you for helping keep our school community safe and healthy!

Fiona Higgins RN WEC

higginsf@tuckahoeschools.org

O: (914) 337-5376 ext 1282

Fax: (914) 337-2367

Jane Devereux RN TMS/THS

devereuxj@tuckahoeschools.org

O: (914) 337-5376 ext 1236

Fax: (914) 337- 4126



Subject: Required Health Forms for Students with Chronic Conditions and Allergies – 2025/26 School Year

Dear Families,

As we prepare for the upcoming 2025–2026 school year, we want to ensure that all students with **chronic health conditions** (such as asthma, diabetes, or seizures) and those with **food allergies** are safe and supported at school.

If your child has a condition requiring an **individual health care plan** and/or **emergency medication** (such as an EpiPen, inhaler, glucagon, or seizure medication), it is essential that we receive the appropriate documentation **before or at the start of the school year**.

Required Documents:

Care Plan/ Emergency Action Plan completed and signed by your child’s healthcare provider.

Medication Authorization Form (required for all medications kept at school)

Where to Find Forms:

All required forms are available for download on the **school website** under the **Nurse’s Office / Health Office tab**.

https://www.tuckahoeschools.org/school_nurse_information

To ensure your child’s safety and compliance with school health protocols, we kindly ask that you submit the completed forms and medications **as early as possible**, preferably before the first day of school.

If you have any questions or need assistance, please don’t hesitate to contact me.

Thank you for your attention to this important matter and for helping us create a safe and supportive environment for your child.

Warm regards,

Fiona Higgins RN WEC

higginsf@tuckahoeschools.org

O: (914) 337-5376 ext 1282

Fax: (914) 337-2367

Jane Deveruex RN TMS/THS

deveruexj@tuckahoeschools.org

O: (914) 337-5376 ext 1236

Fax: (914) 337- 4126

2025-26 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine adolescent booster (Tdap) ³	Not applicable		1 dose given after age 10 years	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart and between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) ⁸	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

*Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months, 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
 - c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
 - d. For further information, refer to the CDC Catch-Up Guidance for Children 4 Months through 6 Years of Age.
 - e. For further information, refer to the CDC Catch-Up Guidance for Children 7 through 9 Years of Age.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 11: 10 years; minimum age for grade 12: 7 years).
 - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
 - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2025-26, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 11; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grade 12.
 - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
 - d. For further information, refer to the CDC Catch-Up Guidance for Children 10 through 18 Years of Age.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months, 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses that are each separated by at least 4 weeks is sufficient.
 - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
 - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward New York State school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.
 - e. For further information, refer to the CDC Catch-Up Guidance for Children 4 Months through 17 Years of Age.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
 - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. Measles: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (pre-kindergarten through 12).
6. Hepatitis B vaccine
 - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
 - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
 - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 12: 10 years).
 - a. One dose of meningococcal conjugate vaccine is required for students entering grades 7, 8, 9, 10 and 11.
 - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
 - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
 - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
 - d. If dose 1 was received at 15 months or older, only 1 dose is required.
 - e. Hib vaccine is not required for children 5 years or older.
 - f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months*. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
 - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
 - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
 - e. PCV is not required for children 5 years or older.
 - f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

*Depending on vaccine brand, schedule may change.

For further information, contact:

New York State Department of Health
 Division of Vaccine Excellence
 Room 649, Corning Tower ESP
 Albany, NY 12237
 (518) 473-4437

New York City Department of Health and Mental Hygiene
 School Compliance Unit, Bureau of Immunization
 42-09 28th Street, 5th floor
 Long Island City, NY 11101
 (347) 396-2433

New York State Department of Health/Division of Vaccine Excellence
 health.ny.gov/immunization

05/25

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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done	
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>	
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>	
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>	
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>	
Notes						
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	
FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK						
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act						
<input type="checkbox"/> Student may participate in all activities without restrictions.						
If Restrictions Apply – Complete the information below						
<input type="checkbox"/> Student is restricted from participation in:						
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.						
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.						
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.						
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V						
<input type="checkbox"/> 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						
<input type="checkbox"/> Order Form for medication(s) needed at school attached						
COMMUNICABLE DISEASE				IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam				<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER						
Healthcare Provider Signature:						
Provider Name: <i>(please print)</i>						
Provider Address:						
Phone:				Fax:		
Please Return This Form to Your Child's School Health Office When Completed.						

THE TUCKAHOE UNION FREE SCHOOL DISTRICT
HEALTH OFFICE
EASTCHESTER, NEW YORK 10707

Health History Section

Name: _____ Grade: _____ D.O.B.: _____

Parent Guardian -- Please answer the following questions by checking the Yes or No box. If **YES**, describe the condition below.

Has your child experienced:

- | | | | |
|-----|---|-----|----|
| 1. | Any serious head injury or concussion? | YES | NO |
| 2. | Any loss of consciousness or a seizure? | YES | NO |
| 3. | Any chronic illness: | YES | NO |
| | asthma _____ bleeding disorder _____ diabetes _____ | | |
| | high blood pressure _____ allergies _____ heart disease _____ | | |
| | other _____ high cholesterol _____ anemia _____ | | |
| 4. | Any disease or injury of the | | |
| | eyes _____ liver _____ ears _____ skin _____ | | |
| | kidneys _____ joints _____ testicles _____ | | |
| | muscles _____ bones _____ nervous system _____ | | |
| 5. | Any injury or illness requiring medical attention | YES | NO |
| 6. | Any illness lasting more than 5 days | YES | NO |
| 7. | Taking any medication or under a physicians care at this time | YES | NO |
| 8. | Wears orthodontic appliance | YES | NO |
| 9. | Any teeth capped or replaced | YES | NO |
| 10. | Started taking a medication regularly? | YES | NO |
| 11. | Chicken Pox/or had infectious mononucleosis? | YES | NO |
| 12. | Had any hospitalization, surgery or fracture? | YES | NO |
| 13. | Does your child wear contact lenses or glasses? | YES | NO |
| 14. | Had a relative who died suddenly before the age of 50?
(i.e. Grandparent, mother, father, brother, sister) | YES | NO |
| 15. | Has your child recently passed out during exercise or stopped exercising
because of dizziness or fatigue? | YES | NO |
| 16. | Has your child ever suffered a heat-related illness? | YES | NO |
| 17. | Does your child see a physician regularly for a specific problem? | YES | NO |
| 18. | Is your child allergic to any medications, bee stings or other allergies? _____ | YES | NO |
| 19. | Chest pain on exertion | YES | NO |
| 20. | Heart palpitations related to exercise? | YES | NO |
| 21. | History of Kawasaki Disease? | YES | NO |
| 22. | History of Lyme Disease? | YES | NO |
| 23. | Diagnosis of Marfans syndrome? | YES | NO |
| 24. | Diagnosis of Turners syndrome? | YES | NO |
| 25. | History of malignancy? | YES | NO |
| 26. | Any condition that may be exacerbated by playing sports? | YES | NO |
| 27. | Any change in eating habits - Wt. Gain _____ Wt. Loss _____ | YES | NO |

Comments:

PARENT/GUARDIAN: I have reviewed the above health history. I hereby certify that the above information is accurate and current and my child does not have any medical condition that would affect participation in sports activities and/or Physical Education classes.

Parent/Guardian's Signature: _____

Student's Signature: _____

PLEASE NOTE: Personal appliances such as glasses, contact lenses, braces and/or Hearing aids involve a certain degree of risk to your child. Parent/Guardian is responsible for loss or damage to such personal appliances.



EMERGENCY INFORMATION CARD

(PLEASE PRINT)

Grade _____ Date _____

Name _____

Birthdate _____

Address _____

Phone _____

Parent/Guardian _____

Address _____

Phone _____

Email _____

Parent/Guardian _____

Address _____

Phone _____

Email _____

List Below 2 neighbors/relatives to call in case of emergency.

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

In case of accident or serious illness Tuckahoe School District will contact the parents or the alternates listed on this form. However, this does not preclude the school from summoning emergency assistance and transporting a child to the hospital emergency room by ambulance if necessary. I will not hold the school district legally or financially responsible for this action.

Signature of Parent/Guardian _____ Date _____

Medical Conditions _____

Allergies _____

Medications _____

Please indicate any accidents, illnesses, or operations in the past 12 months _____

Local Physician's Name _____

Local Dentist's Name _____

Address _____

Address _____

Phone _____

Phone _____



RELEASE TO EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize you to exchange all pertinent and confidential information regarding _____
(Student Name)

I also authorize a representative of the Tuckahoe School District to speak with and exchange information with the person(s)/organization listed below:

The information may be exchanged with:

Agency/Name: _____

This release has been authorized by:

Signed: _____

Relationship: _____

Date: _____

Release

**Tuckahoe School District
Health Offices**

Tuberculosis Screening

**Either A or B *must* be completed by a physician. If either is *not* completed,
this form will be returned**

Patient's Name _____ Date of Birth _____
(please print)

**A).
PPD (Mantoux):**

Date placed _____ Date read _____ Result in mm _____ M.D. initials _____

**B). Tuberculin screening is *not* indicated at this time _____
M.D. initials _____**

Last PPD on record · Date placed _____ result _____

If test result is positive :

Chest x-ray : Date _____ result _____
INH therapy: yes _____ no _____ Date _____

Additional comments: _____

Physician's signature _____ Stamp or Print _____
Date _____

**TUCKAHOE UNION FREE SCHOOL
DISTRICT HEALTH OFFICE**

DENTAL HEALTH CERTIFICATE

Parent/Guardian: New York State Law (Chapter 281) permits school's to request a dental examination in the following grades: school entry, K, 2, 4, 7, and 10. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up, ask your dentist to fill out section 2. Return the completed form to the school nurse as soon as possible. *The date of the exam needs to be within 12 months of the start of the school year in which it is requested.*

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 _____ Grade: _____

Will this be your child's first visit to a dentist? Yes ___ No ___

Section 2. To be completed by the Dentist

The Dental Health condition of _____ on _____
(name of student) (date of exam)

The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Please check the following:

____ 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.

____ Yes, All necessary dental work for the above student has been *completed*.

____ Yes, The student listed above is presently *undergoing* dental treatment.

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 name and address (please print or stamp)

Dentist's Signature:

