SOUTH SENECA CENTRAL SCHOOL

Middle-Senior High School

Telephone Number: 607-869-9636 7263 South Main Street, Ovid, NY 14521 **Fax Number:** 607-869-9553

parcangeli@southseneca.k12.ny.us

607-869-9636 ext. 4102

August, 2011

Dear students and parents:

Another school year is about to begin! I hope your summer has been restful and enjoyable.

Please take the time to fill in and return the enclosed forms. The Emergency form is necessary for many reasons, but especially if we need someone to contact in case of an illness, or injury in school.

If you have medications that you need to take in school, please fill out the form enclosed, and bring your medicine in to the nurse's office in its original container. Tylenol can be given in school with parent permission.

If students have had a physical or immunizations over the summer, please send that in to the health office. Physicals should not be given to coaches, but should come directly to the nurse.

Sports physicals were held last June for the Fall. These physicals are good for one year, and will count as the physical for the 2011-2012 school year. Remember, students must have a physical and have handed in the Athletic Competition Health Screening Form in order to receive the Pink slip that allows you to play.

If you are not going to be in school because you are sick, or have an appointment, a parent should call the attendance clerk in the morning, and follow up by sending a written excuse in to school when you return. We also need a note from parents when students come in late to school. If the student needs to leave school, we will need it in writing. This permission cannot be accepted over the phone. All attendance issues should be directed to Donna Dickens, at extension4151. Notes should be handed in to her in the office. If a student is absent from school for 3

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P. Arcangeli, RN
parcangeli@southseneca.k12.ny.us

Dear Parent or Guardian:

New York State law prohibits the use of any over-the-counter substances in a school Health Office unless they have been individually prescribed by a physician for each student.

During the course of each school day, we see many students for minor cuts, rashes, sore throats, coughs, etc. In order to effectively treat these students, we keep a variety of over-the-counter remedies on hand here in our office. However, we are no longer allowed to use them without the above-mentioned prescription, and parental permission.

The items listed below are kept in our office to be used when deemed appropriate by the school nurse. A brief description of each item is included on the following page, which you may detach and keep. Please complete this form and return it to our office. We will then have the school physician sign it. If you would prefer, you can have it signed by your own physician before returning it to us. PARENTS SHOULD NOTIFY THE SCHOOL OF ANY ALLERGIES TO THE FOLLOWING SUBSTANCES.

Please put a check mark next to any item that we MAY administer to your child:

_____ **Aloe Gel**	_____ **Anbesol**
_____ **Aquaphor**	_____ **Bactine**
_____ **Ben-Gay**	_____ **Betadine Solution**
_____ **Caladryl**	_____ **Chloraseptic**
_____ **Cough Drops**	_____ **Eucerin Cream**
_____ **Hydrogen Peroxide**	_____ **Ipecac Syrup**
_____ **Saline drops/artificial tears**	_____ **Sting-kill swabs**
_____ **Triple Antibiotic Ointment or Neosporin**	_____**Tylenol**

Student's Name_____Birthdate_____
Parent/Guardian Signature _____Date_____
Physician Signature_____Date_____

As always, please feel free to contact our office at 869-9636, ext 4102 if you have any questions or concerns. Thank you.

South Seneca Middle/High School, Ovid, NY

_____should receive the medication prescribed by me and described below, during school hours.

Name of medication:_____

Dosage:_____

Frequency:_____

Diagnosis:_____

_____ _____

Date Signature of Parent

_____

Signature of prescribing Physician

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 visit to a dentist? ☐ 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

I. The Dental Health condition of _____ on _____ (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. 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 name and address (please print or stamp) Dentist'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):_____

III. 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.

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Cathy Flanders, HS Principal
Cflanders@southseneca.k12.ny.us

Steve Zielinski, MS Principal
Szielinskis@southseneca.k12.us

parcangeli@southseneca.k12.ny.us
607-869-9636 ext. 4102
FAX 607-869-4906

Emergency Information Form

Date_____

Student name_____**DOB**_____

Mother's name_____ **Email**_____

Address_____

Mother's home phone_____ **Work phone**_____

Father's name_____**Email**_____

Address_____

Father's home phone_____ **Work phone**_____

Any other phones for parent/guardian_____

Emergency contacts other than parents- Please include phone numbers. These are the people you authorize to take your children home or be notified in case of illness or emergency.

_____

Name **Phone**

_____

Name **Phone**