

**North Shore Schools  
Glen Head, NY 11545**

Dear Parent:

The physical well-being of your child bears an important relationship to his or her progress and success in school. The New York State Education Law requires a physical examination for each child upon entering school and in the second, fourth, seventh and tenth grades. The physical may not be done by a Physician's Assistant unless employed by our school physician.

The school physician cannot make as thorough an examination as can your family physician, who is more familiar with your child's health history. If medical care is needed, your physician can arrange for immediate treatment. In addition, he will also give your child any necessary immunizations. We urge that you utilize your family physician to perform required health examinations. At this time he will fill out the accompanying form under Section II. If we do not receive this completed form by October 1<sup>st</sup>, we will have the school physician perform a brief examination of your child.

The Dental Health Certificate is for completion by your dentist.

You should complete Section I annually and return it to the school in which your child is enrolled before October 1<sup>st</sup>. Please do this even if your family physician and dentist have not completed their examination by that time so we may better meet your child's health needs.

Sincerely yours,

Janice Nunziata, RN  
Health Care Coordinator

**SECTION I**

\_\_\_\_\_ School Entering \_\_\_\_\_ Grade

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Male \_\_\_ Female \_\_\_ \_\_\_\_\_ Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

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Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_ Business Phone \_\_\_\_\_

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Physician to be called in Emergency \_\_\_\_\_ Phone Number \_\_\_\_\_

**EMERGENCY CONTACT** (if parents cannot be reached)

**HEALTH HISTORY**

*This part must be completed each year by parents*

1. Has your child had any illness, injury or operation during the year? \_\_\_\_\_  
Specify (with dates) \_\_\_\_\_
2. Has your child received any immunizations or tests during the past year? \_\_\_\_\_  
Specify (with dates) \_\_\_\_\_
3. Does your child have allergies? \_\_\_\_\_ Specify \_\_\_\_\_
4. Does your child take any medications on a regular basis (excluding vitamins ) \_\_\_\_\_  
Specify \_\_\_\_\_
5. May your child participate in all physical education and sports without restrictions? \_\_\_\_\_  
If not, please explain \_\_\_\_\_
6. Do you have any other information which would aid the school in a better understanding of your child \_\_\_\_\_

**DENTAL HEALTH CERTIFICATE**

This is to certify that I have examined \_\_\_\_\_  
and hereby inform you that (*please check one*) No treatment is Necessary \_\_\_ Treatment in Progress \_\_\_ Treatment Complete \_\_\_

\_\_\_\_\_  
**Dentist's Signature** **Address** **Date**