The Knox School

541 Long Beach Rd., St. James, NY 11780
Tel 631.686.1600 Fax 631.686.1670

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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.

Section 1. To be completed by Parent or Guardian

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 student was evaluated on (Date): ________________________

The date of the assessment needs to be within 12 months of the start of the school year in which this certificate is requested.

□Yes □No The student listed above is in fit condition of dental health to permit his/her attendance at The Knox School.

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 school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address (Stamp):	**Dentist's/Dental Hygienist's Signature:**

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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Required NYS School Health Examination Form

To be completed by a private health care provider or school medical director

Student Information

Student's Name: Last First Middle

Birth Date: / / Month Day Year	Sex: □Male □Female	Grade:	Date of Exam: / / Month Day Year

Health History

Allergies □No □Yes, indicate type	□Food:______ □Insects: ______ □Medication: ______ □Other: ______ □Medication and Treatment Order Attached □Anaphylaxis Care Plan Attached
Asthma □No □Yes, indicate type	□Intermittent □Persistent □Other □Medication and Treatment Order Attached □Asthma Care Plan Attached
Seizures □No □Yes, indicate type	□Type:______ □Date of Last Seizure: ______ □Medication and Treatment Order Attached □Seizure Care Plan Attached
Diabetes □No □Yes, indicate type	□Type 1 □Type 2 □HbA1c results:______ □Date Drawn: ______ □Medication and Treatment Order Attached □Diabetes Medical Management Plan Attached

Physical Examination/Assessment

Height:	**Weight:** **BMI:**	**Temperature:**	**BP:**	**Pulse:**	**Respirations:**	**SpO2:**

Health exam entirely normal
□Yes
□No, specify below in the assessment boxes

Check any assessment boxes *OUTSIDE* normal limits and note below under abnormalities:

□HEENT	□Lymph Nodes	□Abdomen	□Extremities	□Speech
□Dental	□Cardiovascular	□Back/Spine	□Skin	□Social/Emotional
□Neck	□Lungs	□Lungs	□Genitourinary	□Musculoskeletal

Tanner Developmental Stage: □I □II □III □IV □V

Assessment/Abnormalities Noted/Recommendations:

Mental or Emotional Health Concerns:

Other Pertinent Medical Concerns:

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Student Name:	**DOB:**

Screenings

Vision	**Right Eye:** **20/**	**Left Eye:** **20/**	**Referral Needed:** □No □Yes	**Notes:**
Hearing	**Right Ear:**	**Left Ear:**	**Referral Needed:** □No □Yes	**Notes:**
Scoliosis □No □Yes	**Deviation Degree:**	**Trunk Rotation Angle:**	**Referral Needed:** □No □Yes	**Notes:**

Medications

Does this student take medications?
□No
□Yes (specify): ____

____

____

____

*** Please complete the *Medications to be Administered at Knox School* form if student requires medications during the school day.**

Recommendations for Participation in Physical Education and Sports

□**Full Activity** without restrictions including physical education and all sports.

□**Restrictions/Adaptations**
□No Contact Sports (specify): ____

□Non-Contact Sports only (specify):____

□Other Restrictions (specify): ____

Medical Provider Signature:	**Date:**

Medical Provider Name and Address (stamp):

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Student Immunization Record - to be completed by a private healthcare provider or school physicia

Student Name:____________________________________Date of Birth:____________________

New York State (NYS) Public Health Law Section 2164 and New York Codes, Rules and Regulations (NYCRR) Title 10, Subpart 66-1 require every student entering or attending public, private or parochial school in New York State (NYS) to be immune to diphtheria, tetanus, pertussis, measles, mumps, rubella, poliomyelitis, hepatitis B, and varicella in accordance with Advisory Committee on Immunization Practices (ACIP) recommendations. Dose requirements are as follows:

- **Polio (IPV/OPV)** – 4 doses or 3 doses if the 3rd dose was received at 4 years old or older
- **Diphtheria, Tetanus, Pertusis (DTaP/DTP/Tdap/Td)** – 3 or more doses
- **Tdap (Boosterix)** – 1 dose at 11 years old or older
- **Measles, Mumps, Rubella (MMR) –** 2 doses of MMR or 2 doses of measles, 1 dose of mumps, and 1 dose of rubella
- **Hepatitis B** – 3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years
- **Varicella (Chickenpox)** – 2 doses required for grades 6th through 9th. 1 dose for grades 10th through 12th
- **Meningococcal Conjugate (MenACWY)** – 1 dose for grades 7th and 8th. 2 doses for 12th graders or 1 dose if dose was received at 16 years or older

Immunizations	Doses Received (dates)
Polio (IPV/OPV)	1)
	2)
	3)
	4)
Diphtheria, Tetanus, Pertusis (DTaP/DTP/Tdap/Td)	1)
	2)
	3)
	4)
Tdap (Boosterix)	1)
Measles, Mumps, Rubella (MMR)	1)
	2)
Hepatitis B	1)
	2)
	3)
Varicella (Chickenpox)	1)
	2)
Meningococcal Conjugate (MenACWY)	1)
	2)

Healthcare Provider Stamp (including name, address, phone and fax):

Healthcare Provider Signature:____ Date:______________

Student Name: ____ Date of Birth: ________________

Part I: Annual Tuberculosis Risk Assessment Questionnaire

1. Has the student ever had close contact with persons known or suspected to have active TB? Yes No
2. Has this student been a resident and/or employee of high-risk congregate settings (e.g. correctional facilities, long-term care facilities, or homeless shelters)? Yes No
3. Was this student born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please CIRCLE the countries below) Yes No
4. Has this student had frequent or prolonged visits* to one or more of the countries listed below with a high prevalence of TB disease? (If yes CHECK the countries below) Yes No
5. Has this student ever been a volunteer or healthcare worker who served clients who are at increased risk for active TB disease? Yes No

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**The significance of travel exposure should be discussed with a health care provider and evaluated.*

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

If you have answered **YES** to any of the above questions, The Knox School requires that the student receive TB testing ***prior*** to arriving at Knox. Please complete Part II of this form.

If you have answered **NO** to all of the above questions, no further testing or further action is required. Part II is not required.

Parent/Guardian Name: ____________________________________ ***Date:*** ___________________

Parent/Guardian Signature: __________________________________

Student Name: ____ Date of Birth: ___________________

Part II: Clinical Assessment by Health Care Provider Clinicians

Clinical Assessment by Health Care Provider Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are required to complete the Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA).

1. Does this student have a history of a positive TB skin test or IGRA blood test? (If yes, document below) Yes No

2. Does this student have a history of BCG vaccination? (If yes, IGRA test should be performed) Yes No

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Section 1: TB Symptom Check

1. Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes No

If **NO**, proceed to Sections 2 or 3. If **YES**, check any present symptoms below:

- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

Section 2: Tuberculin Skin Test (TST) - *<u>Test results must be from current year</u>*

TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.

Date Given (Month/Day/Year): ____/____/____ Date Read (Month/Day/Year): ____/____/____

Result: ________ mm of induration Interpretation: positive____ negative____

Section 3: Interferon Gamma Release Assay (IGRA) - *<u>Test results must be from current year</u>*

Date Obtained (Month/Day/Year): ____/____/____ (specify method) QFT-GIT T-Spot other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Section 4: Chest X-Ray (required if TST or IGRA is positive) - *<u>Test results must be from current year</u>*

Date of chest x-ray (Month/Day/Year): ____/____/____ Result: normal____ abnormal_____

Health Care Provider Stamp:

Health Care Provider Signature: ____________________________________ ***Date: _________________***

Student Name: ____ Date of Birth: ________________

Part III: Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with M. tuberculosis (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunoileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

______ Student agrees to receive treatment

______ Student declines treatment at this time

Health Care Provider Stamp:

Health Care Provider Signature: ___________________________________ Date: _________________