Berlin
CENTRAL SCHOOL DISTRICT
17400 State Route 22, Cherry Plain, NY 12040 ▮ P.O. Box 259 Berlin NY, 12022
Phone: 518-658-1500

To Berlin Central School District Families,

Welcome to the district! You are joining an amazing community filled with an engaged and wonderful staff that provides enormous opportunities for our students.

We wanted to take this opportunity to introduce you to our nurses, how to contact them, and to provide you with the medical forms needed for school. If your child has a medical condition that requires emergent medication to be administered or has a medical condition(s) you would like us to know about, please reach out to the nurses directly.

First our nurses:
At BES, you will find Becca Galusha, RN ext 3007 and/or Jean Hammond, RN ext 3008.

At MS/HS, you will find Michele Corsey, RN ext 1061 and/or Becca or Jean ext 1060.

Next-the medical information the nurses will need:

- **Immunization Records-**The nurses will need a copy of your child's most up to date list of immunizations-Per NYS-immunization records must be received within 14 days of starting school.
- **Annual Health Certificate (physical)-**NYS requires all new students entering into the district to have had a physical within the last 12 months. The included form can be completed by your health care provider and returned to the health office.
- **Medication Orders/Consent form-**required if you would like your child to receive any medication at school. This includes prescription and over the counter medications. Students are not permitted to self carry medication on person, including over the counter medications such as Tylenol and Ibuprofen.
- **Dental Certificate**
- **HIPPA form**

Please call us with any questions. Our fax numbers are listed below in case you would like to have medical documentation faxed to us. Or, medical forms can be dropped off at the main office during regular school hours or brought to school by your child.

BES fax number-518-658-0482.
MS/HS fax number-518-658-0483.

Have an amazing year!
Your nurses,

Michele Corsey, RN
mcorsey@berlincentral.org

Jean Hammond, RN
jhammond@berlincentral.org

Rebecca Galusha, RN
rgalusha@berlincentral.org

Berlin Central School District
Health History Form

Student's Name _____ _____Male _____Female

Date Form Completed _____

Mailing Address _____

911 Address _____

Child's Date of Birth _____ Place of Birth _____

Father's Name _____ Home Phone _____

Mother's Name _____ Step-parent/Guardian Name _____

Child lives with: (please circle) Both Parents Mother Father

Custody of child belongs to: (please circle) Both Parents Mother Father

Family Physician _____ Phone Number _____

Family Dentist _____ Phone Number _____

Hospital Preference _____ Health Insurance Company _____

_____

Please indicate if your child has had any of the following, giving dates if possible:

Whooping Cough _____ Chicken Pox _____ Eczema _____
Poliomyelitis _____ Scarlet Fever _____ Diabetes _____
Diphtheria _____ Rheumatic Fever _____ Epilepsy _____
Rubella _____ Pneumonia _____ Asthma _____
Mumps _____ Tuberculosis _____ Ear Infections _____
Measles _____ Hepatitis _____ Anemia _____
Other Diseases _____

Is there any family history of the following? (please circle) Diabetes Heart Disease Kidney Disease

Has your child had any serious illness, injury or hospitalization? YES NO (Please explain on back of form)

Does your child have any allergies? YES NO (Please explain on back of form)

Does your child take any medication ? YES NO (Please list on back of form)

Does your child have any vision problems? YES NO
If yes, please explain: _____

Does your child have any hearing problems? YES NO
If yes, please explain: _____

Does your child have any orthopedic problems? YES NO
If yes, please explain: _____

Does your child have any dental problems? YES NO
If yes, please explain: _____

Is your child currently under the care of a doctor or dentist? YES NO
If yes, please explain: _____

Please explain any serious illnesses, injuries, or hospitalizations: _____

_____

_____

_____

Please list all allergies to:

Food _____

Medication _____

Environmental Factors _____

Please list all medications:

Daily Medications _____

As Needed Medications _____

Please use the space below to explain anything else you would like us to know about your child:

_____

_____

_____

_____

PLEASE COMPLETE CURRENT MEDICAL INFORMATION AS REQUESTED ON THIS FORM AND SUBMIT ALL WRITTEN MEDICAL DOCUMENTATION AS REQUESTED FROM HEALTH CARE PROVIDERS

MEDICAL DOCUMENTATION REQUESTED FROM YOUR HEALTH CARE PROVIDERS:

Physical Examination – Please provide a copy of a physical examination from your child's physician. **Please note: If a copy of a physical examination is not received within 30 days of entry, your child will be scheduled for a physical examination from the school's physician.**

Immunization Records – Please attach a copy of your child's complete immunization record from a physician. **Please note: Immunizations are required within 10 days of school entry for students entering from New York State and within 30 days of entry from outside of New York State. If immunizations are not received within the appropriate amount of time or are incomplete, your child will be excluded from school until the necessary immunizations or documentation has been received in accordance with New York State education law.**

Dental Health Certificates – In accordance with New York State education law effective September 2009, all students entering school are requested to provide proof of a complete dental examination by a NYS licensed dentist. A list of dentists providing reduced or no cost dental services can be provided to you at your request.

Parent/Guardian Signature: _____ **Date;** _____

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:**

Laboratory Testing	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.**

If Restrictions Apply – 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 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: ☐ 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.

Berlin
CENTRAL SCHOOL DISTRICT
17400 State Route 22, Cherry Plain, NY 12040 ▮ P.O. Box 259 Berlin NY, 12022
Phone: 518-658-1500

A NOTICE FROM THE HEALTH OFFICE

January 30, 2026

To all Berlin Central School District families,

We hope the new year is starting off to a good start for your family. The health office wanted to reach out to you to notify you that the Food and Drug Administration has updated its list of ingredients of what is considered over-the-counter-medication.

In order for a school nurse to administer medication in New York State, the nurse must have a doctor's order (note) and your consent. We've included an updated medication form. If you would like to have your child receive any of the items listed on this form, your signature AND your doctor's signature must be provided on the attached form. Forms turned in at the beginning of the school year are still valid for the medications listed on them. All medication orders/forms are valid for a period of one year from the date on the form.

Please reach out to your school nurses if you have any questions.

Your school nurses,

Michele Corsey, RN
Jean Hammond, RN
Rebecca Galusha, RN

BES Fax Number: 518-658-0482
BMHS Fax Number: 518-658-0483

Berlin
CENTRAL SCHOOL DISTRICT
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MEDICATION CONSENT FORM

To be completed and signed by the student's Licensed Health Care Provider and parent/guardian.
New York State law requires that all medication orders for students be patient specific.

Section I: Indicate approval/disapproval of the following over the counter medications & treatments for use at school. **Valid for one year from date of signature.**

Students **CANNOT** self-carry these medications

Medication Name	Dosage & Indication For Use	Physician Approval	Physician Disapproval	Concerns/ Comments
Acetaminophen (Tylenol)	Per label instructions Per age/wt.	Yes ____	No _____	
Ibuprofen (Motrin)	Per label instructions Per age/wt.	Yes ____	No _____	
Bacitracin/Neosporin (Antibiotic) Ointment	Per Label Instructions	Yes ____	No _____	
Burn Ointment/cream	Per Label Instructions	Yes ____	No _____	
Benzalkonium Chloride (Antiseptic)	Per Label Instructions	Yes____	No_____	
Caladryl (Anti-itch) Lotion	Per Label Instructions	Yes ____	No _____	
70 % Isopropyl Alcohol (First Aid Antiseptic)	Per Label Instructions	Yes____	No_____	
Antiseptic Solution	Per Label Instructions	Yes ____	No _____	
Sunscreen/Sunblock	Per Label Instructions	Yes ____	No _____	
Cough Drops	Per Label Instructions	Yes ____	No _____	
Tums (Stomach Relief)	Per label instructions	Yes ____	No _____	

Section II: Miscellaneous Items (Personal Hygiene Products)

Product	Dosage & Indication for use	Physician Approval	Physician Disapproval	Concerns/Comments
Toothpaste	Per label instructions	Yes_____	No_____	
Antiperspirants/ Deodorants	Per label instructions	Yes_____	No_____	
Aloe/Cocco butter	Per label instructions	Yes_____	No_____	
				See next page ➜

Section II continued:				
Skin lotion/Petroleum jelly/ Vaseline	Per label instructions	Yes____	No_____	
Chapstick	Per label instructions	Yes____	No_____	
Table Salt (Sodium Chloride NaCL)	Per label instructions	Yes_____	No_____	
Contact Lens Solutions/Saline Solution	Per label instructions	Yes_____	No_____	
Hand Sanitizer	Per label instructions	Yes_____	No____	

Section III: Please list student's use of prescription and/or non-prescription medications and indicate the need for use at school. **Parents are responsible for providing these medications**.

Medication	Route	Dosage	Frequency/Indications	Comments	Use at School
					Yes/No
					Yes/No
					Yes/No

Section III: Please provide the appropriate signatures and return to the Health Office.Licensed Provider's Name: _____ Phone Number: _____

Licensed Provider's Signature: _____Date: _____

Student's Name: _____DOB:_____ Allergies:_____

Parent Signature: _____ Date: _____

Return to your school's nurse when all sections have been completed.

Berlin MS/HS fax:518-658-0483 **Berlin Elementary Fax**: 518-658-0482

(1/2026)

Berlin Central School District

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: New to the district ,Pre-K or K, 1, 3, 5, 7, 9 & 11. 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.

BERLIN CENTRAL SCHOOL DISTRICT
PO BOX, 259, BERLIN, NY 12022
(518) 658-1500 (Phone) (518) 658-0483 (Fax)

AUTHORIZATION TO RELEASE/RECEIVE HEALTH INFORMATION PURSUANT TO "HIPAA"

Students Name: _____ DOB: _____

I, _____, hereby authorize Berlin Central School District, PO Box 259, Berlin, NY 12022 to release/receive records pertaining to _____.

The type and amount of information to be released or disclosed is as follows:

_____

_____

_____

The information specified above is authorized to be released/received:

To:	**From:**
Name:	Name:
Address:	Address:
Agency:	Agency:

The purpose for the disclosure of the specified information is for the purpose of:

_____

_____

_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: If I fail to specify an expiration date, event or condition, this authorization will expire at the end of the current school year.

I understand that authorizing the disclosure of this health information is voluntary. I understand I may inspect or copy the information to be used or disclosed, as provided above. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Student or Legal Parent/Guardian: Date:

_____ _____

(If not signed by student, relationship to student)

Berlin Central School District

PO Box 259, Berlin, NY 12022

Berlin Elementary School
Phone (518) 658-1500 ext. 3008
Fax (518)658-0482
Jean Hammond, RN
jhammond@berlincentral.org

Berlin Middle/High School
Phone (518)658-1500 ext 1061
Fax (518) 658-0483
Michele Corsey, RN
mcorsey@berlincentral.org

Dear Berlin School District Families,

Each year, the Rensselaer County Department of Youth donates backpacks with supplies to our district families in need for children **entering kindergarten through eighth grade**. Backpacks are available to be picked up at the MS/HS front office sometime in August. You will be notified when the bags are ready for pick up.

If you would like to participate in the backpack program, please complete and return this form to Michele Corsey, School Nurse, Berlin Central School District, PO Box 259, Berlin, NY 12022, **no later than June 25, 2024**. Your child's first name, last initial and grade will be shared with the Rensselaer County Department of Youth for record keeping purposes only. In the event all requests cannot be accommodated, requests will be honored in the order the forms are received.

___I do/do not (circle one) give permission for my child's name to be shared with Rensselaer County.

Parent Signature_____

Phone number (_____)_____ Email _____

Please complete **one** form per household.

Child's Name	**Grade entering in September**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Have a happy and safe summer!

Sincerely,

Your Health Office Team