BEACON CITY SCHOOL DISTRICT
ADMINISTRATIVE OFFICES
10 Education Drive
Beacon, New York 12508
845-838-6900
www.beaconk12.org

Ms. Ann Marie Quartironi
Deputy Superintendent

Dr. Heather Chadwell Dennis
Assistant Superintendent of Personnel and Policy

Ms. Sagrario Rudecindo-O'Neill
Assistant Superintendent of Curriculum and Student Services

Dr. Matthew Landahl
Superintendent of Schools

Dear Parent(s) or Guardian(s):

New York State law requires that each child in a school district have a health examination including body mass index before entering school for the first time, and again in grades 1, 3, 5, 7, 9, 11. Students wishing to play interscholastic sports or requesting work permits must have an annual health exam. A dental exam form is also requested for these grades as well, but not required.

Your own health care provider is always the best choice for these exams. We encourage you to call early as it may take several weeks to schedule exams during the busy summer and fall months.

We have included the NYS Health Examination form for your health provider to complete. We can accept this form dated after **September 4th 2023 for the 2024-25 school year**. You or your provider may return the completed form to the school health office or email it to **aakjar.h@beaconk12.org, or your child's school nurse.**

If you do not provide an exam form by **November 1st, 2024**, an exam will be scheduled with our schools medical director. Please let your child know they will be examined at school.

Upon completion of in-school exams, you will be informed of any important findings and need to follow up with your healthcare provider.

Please Complete And Return The Bottom Portion To Your Building Health Office Today

……✂……..……✂……✂…….

Student's Name _____ **Grade** _____

Student's School _____

- ☐ My child had a health exam on _____. I will return the completed form by the date above.
- ☐ My child has an appointment to have a physical with his/her health care provider on _____
- ☐ My child's MD/NP/PA or I will return the form by the date above.
- ☐ Schedule the district physician to complete the exam for my child.

Parent Name: _____ Date: _____

Parent's Signature: _____

Parent Phone Contact: _____