THE APPROPRIATE FORMS SHOULD BE COMPLETED AND RETURNED TO THE SCHOOL HEALTH OFFICE ON OR BEFORE THE FIRST DAY OF SCHOOL.

This packet includes the following forms:
1. Health Services Information
2. Immunizations (as of 4/18)
3. Health Physical (Grades N-5)
4. Health Physical (Grades 6-8)
5. Dental Form
6. Tdap and Varicella Vaccine Information
7. Procedure for the Administration of Medication and Medical Monitoring in School
8. Parent & Physician Authorization for Administration of Medication in School and School Activities
9. Emergency Information Sheets (2)

HEALTH SERVICES INFORMATION

School nurses offer vital services to the students of the community. These services may include participating in health counseling, screening test, annual health examinations, athletic physicals and emergency care.

Please review the following regulations, which have been designed to protect the health and safety of all our school children.

The law requires that all children entering school must submit a complete record of immunization against measles, diphtheria, polio, mumps, and rubella, pertussis, tetanus, Varicella (chicken pox) and Hepatitis B. A physical examination report must also be submitted. No child will be permitted to attend school without the proper immunizations.

Physical Examination

Parents and guardians are required to have their children examined by their private physicians and dentists on an annual basis. The law requires new entrants, nursery students, pre-kindergartners, kindergarteners, and students in grades 1, 3, 5, 7, 9, and 11 to furnish a physical examination report by October 1st.

Athletic Physicals

All students that plan to participate in an after-school sport must have an athletic physical prior to the season. The physical may be performed by a private physician.
Administering Medication

The Board of Education expects children’s medication to be administered at home. Under certain circumstances, when it is necessary for the child to take internal medication during school hours, the following guidelines must be strictly followed:

1. Medical Necessity Accommodation Request Form
2. A written order from the physician must be submitted
3. A written medication form from the health office must be signed by the parent or guardian
4. The medication must be brought to school by an adult in the proper container labeled by the pharmacist or physician

Medication regulations apply to both non-prescription and prescription medications. The Nurse’s Office does not have nebulizer treatment equipment available. If a nebulizer treatment is needed, the parent must provide nebulizer tubing and medication, along with the physician’s orders.

Screening Tests

School nurse’s conduction the following screening programs for children in our school:

- **Scoliosis:** Grades 5, 7 (GIRLS ONLY)
- **Vision:** Grades K, 1, 3, 5, 7
- **Hearing:** Grades K, 1, 3, 5, 7

Emergency Health Services

Primary responsibility for school emergency health services rests with the school health services staff. The staff provides first aid whenever appropriate. First aid is emergency care that will protect the life and comfort of an individual until authorized medical treatment is secured. The comprehensive emergency services at St. Edward the Confessor School are designed to educate, prevent incidents and deliver adequate and appropriate care. Please complete the Emergency Information supplied each year so that we can maintain accurate student records.

Absences

If your child will be absent for any reason, please call the Health Office each day at (516) 921-7767 ext. 130. An automated call is generated when your child is not in school regardless if you called in their absence or not.

Illness at School

The nurse at your school will contact you if your child is ill. It is advisable, however, to keep your child home from school, and if necessary to consult your private physician if your child has the following symptoms:

- Elevated temperature (100.1 or above)
- Reddened or discharging eyes
- Nausea or vomiting
- Skin eruption
- Earache
- Diarrhea
- Coughing
- Sore throat

It is the parent/guardian’s responsibility to arrange transportation for his or her ill child. **We have no accommodations for the day for a sick child.**
Please notify the school nurse if your child has a communicable disease or other medical condition or a change in a known medical condition and/or injury. Medical documentation may be requested by the nurse. **By law**, school nurses may **not** diagnose illnesses or injuries. We request that you do not send your child to the Health Office for treatment or diagnoses of old injuries or other chronic conditions. Please feel free to contact the school nurse at your child’s school for information about health services or health education instruction. We appreciate your cooperation and support of our health education programs.
Dear Parents/Guardians,

New York State Department of Health mandates that students entering 7th and 12th grade will require the **Meningococcal Vaccine**. It is not a new vaccine and has been recommended for a decade.

Now, **it is mandatory** that the vaccine is **required** for school entry as of September 1, 2018. **Without it, they can’t start school.**

It’s best to check with your physician to see whether or not your child needs the vaccine.

If you have any Questions or Concerns, please call me at: (516) 921-7767

Sincerely,

Cathy Ciacco, RN
School Nurse

Student’s Name: _____________________________________________________________

Date of Birth: _____________________________________________________________

Date of Meningitis Vaccine: _________________________________________________

MD Signature: ____________________________________________________________

MD Stamp: _______________________________________________________________
Dear Parents/Guardians,

New York State Department of Health mandates that students who are entering 6th grade require 2 immunizations:
- **Tdap** (described below) and a
- 2nd dose of **Varicella** – a health care provider’s signed medical record indicating the student had a varicella disease is acceptable proof of immunity.

Students who are entering 6th grade and who are 11 years of age or older must receive an immunization containing tetanus toxoids, diphtheria, and acellular pertussis (Tdap).

Students who are 10 years old and entering 6th grade will not be required to receive the Tdap vaccine until they turn 11 years old. At that time they must provide documentation of having received the Tdap vaccine or proof of an appointment within 14 days. Without the proper documentation, your child will be excluded from school.

If you have any questions or concerns, please call me at (516) 921 – 7767 ext. 130.

Sincerely,
Cathy Ciacco, RN
School Nurse

NAME OF STUDENT__________________________________________

DATE OF BIRTH____________________________________________

DATE OF BOOSTRIX OR ADACEL VACCINE_______________________

DATE OF 2ND DOSE OF VARICELLA____________________________

MD STAMP AND SIGNATURE____________________________________
Dear Parents/Guardians,

As of July 1, 2018, New York State law requires a health examination for all students entering the school district for the first time and when entering N, Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade.

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner and on the approved NYSED Student Health Examination Form for School.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K, 1st, 3rd, 5th, 7th, 9th, & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care providers is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the same time of your child’s appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number below.

Please see the additional letter included to describe two important changes coming in 2018-2019 school year. After reviewing, please share the letter with your provider.

Sincerely,

Cathy Ciacco, RN
Phone: 516-921-7767 ext. 130
Fax: 516-921-0481
REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

**STUDENT INFORMATION**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex: M</th>
<th>F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
<td></td>
</tr>
</tbody>
</table>

**HEALTH HISTORY**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>□ No</th>
<th>□ Yes, indicate type</th>
<th>□ Food</th>
<th>□ Insects</th>
<th>□ Latex</th>
<th>□ Medication</th>
<th>□ Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>□ No</td>
<td>□ Yes, indicate type</td>
<td>□ Intermittent</td>
<td>□ Persistent</td>
<td>□ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td>□ No</td>
<td>□ Yes, indicate type</td>
<td>□ Type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>□ No</td>
<td>□ Yes, indicate type</td>
<td>□ Type 1</td>
<td>□ Type 2</td>
<td>□ HbA1c results:</td>
<td>Date Drawn:</td>
<td></td>
</tr>
</tbody>
</table>

**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:** □ No | □ Yes

**Hypertension:** □ No | □ Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BP:</th>
<th>Pulse:</th>
<th>Respiration:</th>
</tr>
</thead>
</table>

**Tests**

<table>
<thead>
<tr>
<th>Tests</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD/PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td>One Functioning: □ Eye</td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td>□ Concussion - Last Occurrence:</td>
</tr>
<tr>
<td>Lead Level Required</td>
<td>Grades Pre-K &amp; K</td>
<td>Date</td>
<td>□ Mental Health:</td>
<td>□ Other:</td>
</tr>
</tbody>
</table>

**System Review and Exam Entirely Normal**

**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 |
- □ Genitourinary |
- □ Neurological |
- □ Musculoskeletal |

**Assessment/Abnormalities Noted/Recommendations:**

<table>
<thead>
<tr>
<th>Diagnoses/Problems (list)</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information Attached**

Rev. 5/4/2018  Page 1 of 2
Name: 

DOB: 

SCREENINGS

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Color</td>
<td></td>
<td></td>
<td>□ Pass</td>
<td>□ Fail</td>
</tr>
</tbody>
</table>

Hearing

<table>
<thead>
<tr>
<th>Pure Tone Screening</th>
<th>Right dB</th>
<th>Left dB</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Yes</td>
</tr>
</tbody>
</table>

Scoliosis

<table>
<thead>
<tr>
<th>Required for boys grade 9</th>
<th>Negative</th>
<th>Positive</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td></td>
<td></td>
<td>□ Yes</td>
</tr>
</tbody>
</table>

Deviation Degree: Trunk Rotation Angle:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ Full Activity without restrictions including Physical Education and Athletics.

☐ Restrictions/Adaptations

☐ No Contact Sports

☐ No Non-Contact Sports

☐ Other Restrictions:

☐ Developmental Stage for Athletic Placement Process ONLY

Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports

Student is at Tanner Stage: □ I  □ II  □ III  □ IV  □ V

☐ Accommodations: Use additional space below to explain

☐ Brace*/Orthotic

☐ Colostomy Appliance*

☐ Hearing Aids

☐ Insulin Pump/Insulin Sensor*

☐ Medical/Prosthetic Device*

☐ Pacemaker/Defibrillator*

☐ Protective Equipment

☐ Sport Safety Goggles

☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain:

MEDICATIONS

☐ Order Form for Medication(s) Needed at School attached

List medications taken at home:

IMMUNIZATIONS

☐ Record Attached  ☐ Reported in NYSIIS  Received Today: □ Yes □ No

HEALTH CARE PROVIDER

Medical Provider Signature: 

Date: 

Stamp: 

Provider Name: (please print)

Provider Address: 

Phone: 

Fax: 

Please Return This Form To Your Child’s School When Entirely Completed.
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prekindergarten (Day Care, Head Start, Nursery or Pre-K)</strong></td>
<td></td>
</tr>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis Vaccine (DTaP/DTP)</td>
<td>4 doses</td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps and Rubella vaccine (MMR)</td>
<td>1 dose</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox) vaccine</td>
<td>1 dose</td>
</tr>
<tr>
<td>Hemophilus influenzae type b conjugate vaccine (Hib)</td>
<td>1 to 4 doses</td>
</tr>
<tr>
<td>Pneumococcal Vaccine (PCV)</td>
<td></td>
</tr>
<tr>
<td><strong>Kindergarten through Grade 4</strong></td>
<td></td>
</tr>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis Vaccine (DTaP/DTP)</td>
<td>5 doses or 4 doses if the 4th dose was received at 4 yrs old or 3 doses if 7 yrs old or older and started the series after 1 yr or older</td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)</td>
<td>4 doses or 3 doses if the 3rd dose was received at 4 yrs old or older and at least 6 months from previous dose.</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella vaccine (MMR)</td>
<td>2 doses (2 measles, 2 mumps 1 rubella)</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>3 doses</td>
</tr>
<tr>
<td>Varicella (Chickenpox) vaccine</td>
<td>2 doses</td>
</tr>
<tr>
<td><strong>Grades 5</strong></td>
<td></td>
</tr>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis Vaccine (DTaP/DTP)</td>
<td>5 doses or 4 doses if the 4th dose was received at 4 yrs old or 3 doses if 7 yrs old or older and started the series after 1 yr or older</td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)</td>
<td>3 doses</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella vaccine (MMR)</td>
<td>2 doses (2 measles, 2 mumps 1 rubella)</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>3 doses</td>
</tr>
<tr>
<td>Varicella (Chickenpox) vaccine</td>
<td>1 dose</td>
</tr>
<tr>
<td><strong>Grades 6 through 10</strong></td>
<td></td>
</tr>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis Vaccine (DTaP/DTP)</td>
<td>3 doses</td>
</tr>
<tr>
<td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)</td>
<td>1 dose</td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)</td>
<td>4 doses or 3 doses if the 3rd dose was received at 4 years of age or older</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella vaccine (MMR)</td>
<td>2 doses (2 measles, 2 mumps 1 rubella)</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>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 - 15 years of age</td>
</tr>
<tr>
<td>Varicella (Chickenpox) vaccine</td>
<td>2 doses</td>
</tr>
<tr>
<td><strong>Grades 7, 8, 9, and 12</strong></td>
<td></td>
</tr>
<tr>
<td>Meningococcal vaccine</td>
<td>1 dose in grades 7 if not received in grade 7, must obtain in grade 8 and 9 <em>(per move up schedule)</em></td>
</tr>
<tr>
<td></td>
<td>2 doses in grade 12 unless 1 dose was given on or after the age of 16</td>
</tr>
<tr>
<td><strong>Grades 11 through 12</strong></td>
<td></td>
</tr>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis Vaccine (DTaP/DTP)</td>
<td>3 doses</td>
</tr>
<tr>
<td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)</td>
<td>1 dose</td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)</td>
<td>3 doses</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella vaccine (MMR)</td>
<td>2 doses (2 measles, 2 mumps 1 rubella)</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>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 - 15 years of age</td>
</tr>
<tr>
<td>Varicella (Chickenpox) vaccine</td>
<td>1 dose</td>
</tr>
</tbody>
</table>
St. Edward the Confessor School
Syosset, New York
CERTIFICATE OF NEW YORK STATE IMMUNIZATIONS

NAME: ___________________________ DOB: ________ GRADE: ________

<table>
<thead>
<tr>
<th>IMMUNIZATION</th>
<th>MM/DD/YY</th>
<th>IMMUNIZATION</th>
<th>MM/DD/YY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DTaP/DTP</strong></td>
<td>1. _____</td>
<td><strong>MMR</strong> *</td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>2. _____</td>
<td><strong>OR</strong></td>
<td>2. _____</td>
</tr>
<tr>
<td></td>
<td>3. _____</td>
<td><strong>MEASLES</strong> *</td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>4. _____</td>
<td></td>
<td>2. _____</td>
</tr>
<tr>
<td></td>
<td>5. _____</td>
<td>Child had disease</td>
<td></td>
</tr>
<tr>
<td><strong>Td/DT</strong></td>
<td>1. _____</td>
<td><strong>MUMPS</strong> *</td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>2. _____</td>
<td>Child had disease</td>
<td></td>
</tr>
<tr>
<td><strong>TdaP</strong></td>
<td>1. _____</td>
<td><strong>RUBELLA</strong> *</td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>2. _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>POLIO</strong></td>
<td>1. _____</td>
<td>*<em>Varicella</em>/</td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>2. _____</td>
<td><strong>VARIVAX</strong></td>
<td>2. _____</td>
</tr>
<tr>
<td></td>
<td>3. _____</td>
<td>Child had disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. _____</td>
<td><strong>PCV/Prevnar</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hib</strong></td>
<td>1. _____</td>
<td><strong>PCV 13</strong></td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>2. _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>1. _____</td>
<td>ROTOVIRUS</td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>2. _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. _____</td>
<td>*<em>MENACTRA</em></td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>MENOMUNE</strong></td>
<td>2. _____</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>1. _____</td>
<td>HPV/GARDASIL</td>
<td>1. _____</td>
</tr>
<tr>
<td></td>
<td>2. _____</td>
<td></td>
<td>2. _____</td>
</tr>
<tr>
<td></td>
<td>3. _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TB/PPD __________ RESULT __________ CHEST X-RAY __________ BCG __________

** NYS Mandated
* Please indicate if child had the disease

DATE ________ PHYSICIAN’S SIGNATURE ____________________________

PHYSICIAN’S STAMP & PHONE NUMBER ____________________________
St. Edward the Confessor School  
Syosset, NY

Dental Health Certificate

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 nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td>Sex:</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Will this be your child's first visit to a dentist?</td>
<td>Yes</td>
</tr>
<tr>
<td>School:</td>
<td></td>
</tr>
<tr>
<td>Grade:</td>
<td></td>
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<tr>
<td>Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?</td>
<td>Yes</td>
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</table>

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 (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.

☐ 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 1 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.

HF 4S (rev 9/08)
PROCEDURE FOR THE ADMINISTRATION OF MEDICATION AND MEDICAL MONITORING IN SCHOOL

Dear Parent or Guardian,

In compliance with New York State Education Law, the following procedures must be followed for the administration of any prescription and non-prescription medications. The purpose of this procedure is to protect and prevent your child from the possible hazards of sharing medications with the other students, losing medications and not receiving the medications as prescribed.

PROCEDURE

1. The School Nurse must have on file a signed consent form from the parent or guardian and license prescriber. The consent must be completed each school year.

2. All medications should be delivered directly to the school nurse by the parent/guardian.

3. Prescription medications must be delivered in the original prescription container.
   a. Student Name
   b. Name and phone number of pharmacy
   c. Licensed prescriber’s name
   d. Date and number of refills
   e. Name of medication and dosage
   f. Frequency of administration
   g. Route of administration and/or other directions

4. Non-prescription and medications must be in the original manufacturer’s container with the student’s name affixed to the container.

5. To carry and self-administer medication, the school nurse must receive a request from a parent/guardian and the licensed prescriber permitting the student to self-administer medication.

6. For the children who require additional medical monitoring or treatment, the school nurse must receive a written order from a licensed prescriber including the type of monitoring/treatment, the frequency of monitoring/treatment, the specific parameters of monitoring/treatment.

7. The parent/guardian must provide the properly labeled monitoring/treatment supplies, and provide the proper maintenance and up-keep of the equipment and ensure its good working order.

8. The parent/guardian must inform the school nurse of any change in the child’s medical condition.
IHP Discussed with Parent/Guardian Date: _______ Initials: _______

PARENT & PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name (Last, First) ___________________________________________ DOB ________________
Address _________________________________________________ Phone __________

A: TO BE COMPLETED BY A PARENT OR GUARDIAN
I request that my child _________________________________ grade ________ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished in the properly labeled original container from the pharmacy.

Check the appropriate line:  
____ School Year: Sept____- June ___

____ I understand that the administration of the oral, topical, inhalant, injectable medications to my non self-directed child must remain the responsibility of the school nurse, physician, or a parent.
____ I understand the school nurse, or other designated person in the case of absence of the school nurse, will supervise and assist in administering the medication, including field trips to my self-directed child (see back of form).
____ My child is permitted to self-carry and self-administer the medication (MS and HS only).

I acknowledge my obligation to inform the school nurse of any change in my child’s medical condition.

B: TO BE COMPLETED BY AND SIGNED BY PHYSICIAN
Name of student: ___________________________________________ Date: ________________

Diagnosis:  

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency/Time to Be Taken</th>
<th>Route of Administration</th>
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</table>

Duration of Treatment: _______________________________________
Common Side Effects/Adverse Reactions (if any): __________________________
Circle all that apply:  
Child requires assistance/supervision
Child may self-carry/self-administer

Physician’s Name (Print)        Physician’s signature        Date        Stamp
STUDENT EMERGENCY INFORMATION

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE AS SOON AS POSSIBLE

Student’s Name: ____________________________  Sex: ____________________  Grade: ____________

Date of Birth: ____________________________  Place of Birth: ____________________________

Parents’/Guardians’ Name(s):

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
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<tbody>
<tr>
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<td>__________</td>
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</tbody>
</table>

Address: __________________________________________

Home Phone: ____________________  Cell Phone: ____________________  Work Phone: ____________________

Name: ____________________________

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>

Address: __________________________________________

Home Phone: ____________________  Cell Phone: ____________________  Work Phone: ____________________

Physician: ____________________________  Phone: ____________________

Dentist: ____________________________  Phone: ____________________

If Parents/Guardians not available, in emergency calls: (This is also an authorization to release my child to the adults listed below.) Please inform persons listed below that their names appear as emergency contacts.

Name: ____________________________  Phone: ____________________

Name: ____________________________  Phone: ____________________

Name: ____________________________  Phone: ____________________

1. Has your child had any serious illness, injury or operation during the past year? Yes: ________ No: ________

Specify: ____________________________________________________________________________________________

2. Has or does your child receive(d) any medication on a regular basis? Yes: ________ No: ________

Specify: ____________________________________________________________________________________________

3. Does your child have asthma, diabetes, epilepsy, a heart or orthopedic condition? Yes: ________ No: ________

Specify: ____________________________________________________________________________________________

4. Does your child have any allergies? Yes: ________ No: ________

Specify: ____________________________________________________________________________________________

5. Does your child have any vision or hearing problems? Yes: ________ No: ________

Specify: ____________________________________________________________________________________________

6. Do you have any other information which would help the school in a better understanding of your child? ______

____________________________________________________________________________________________________

7. Has your child received any immunizations, tests, or had a physical exam in the past year? Yes: _____ No: _____

Specify with dates: ____________________________________________________________________________________________

Date: ____________________________________________  Parent/Guardian Signature

Please use reverse side for additional emergency names and numbers.

THIS IS OUR ONLY MEANS OF COMMUNICATION WITH YOU IN AN EMERGENCY DURING SCHOOL HOURS.
**SPECIAL EMERGENCY CARD**

(Please print all information)

Name: ____________________________________________________________ Grade: ____________

Father’s Cell: ( ) ___________________________       Home Phone: ____________________________

Father’s Business: ( ) ____________________________

Mother’s Cell: ( ) ___________________________       Home Phone: ____________________________

Mother’s Business: ( ) ____________________________

PERSONS TO BE CALLED (OTHER THAN PARENTS) THAT CHILD MAY BE RELEASED TO IN AN EVENT OF AN EMERGENCY (MUST HAVE AT LEAST ONE PERSON ON THIS CARD):

1. ______________________________________________

   **NAME** ________________________________

   **RELATIONSHIP** ________________________________

   Home Phone: ( ) ____________________________

   Cell Phone: ( ) ____________________________

   Business Phone: ( ) ____________________________

2. ______________________________________________

   **NAME** ________________________________

   **RELATIONSHIP** ________________________________

   Home Phone: ( ) ____________________________

   Cell Phone: ( ) ____________________________

   Business Phone: ( ) ____________________________

3. ______________________________________________

   **NAME** ________________________________

   **RELATIONSHIP** ________________________________

   Home Phone: ( ) ____________________________

   Cell Phone: ( ) ____________________________

   Business Phone: ( ) ____________________________