TUCKAHOE
UNION FREE SCHOOL DISTRICT

Health Screenings and Immunizations Needed For The 2020-21 School Year

Dear Tuckahoe Union Free School District Community,

As we begin to prepare for the 2020-21 school year, our primary concern remains the health and safety of our students. To that end, please be aware of the following health screening and immunization requirements needed to officially start the new school year:

Health Screenings and Immunizations Needed For The 2020-21 School Year. 2020 Health Examination Form (physicals) forms must be submitted at the start of the following grade levels for a child to attend school:

K, 1, 3, 5, 7, 9, and 11 *All new students to the District (regardless of incoming grade level)*

Please submit all Health Physicals and immunizations forms along with any other medical forms (see below) needed for the student prior to the start of the 2020/2021 school year. They can be submitted via email to Higginsf@tuckahoeschools.org for K-5 and nurse@tuckahoeschools.org for 6-12 postal mail to William E Cottle School Attn School Nurse or TMS/THS Attn School Nurse.

The Health Packet tab has all forms needed. If the student has any of the noted conditions below please print forms accordingly. Food allergy care plans, Asthma care plans, Seizure care plan, Diabetes care plan, OTC/prescription medicine authorization all can be printed out from the TUFSD Health page. https://www.tuckahoeschools.org/school_nurse_information.

Immunizations Required 2020/2021 School Year: K to 5th Grade

(Dtap/DTP/Tdap) 5 doses or 4 doses if the 4th dose was received at 4 years old or older.
Hepatitis B vaccine 3 doses
Measles, Mumps and Rubella vaccine (MMR) 2 doses
Polio vaccine (IPV/OPV) 4 doses or 3 doses if the 3rd dose was received at 4 years old or older.
Varicella (Chickenpox) vaccine 2 doses

Additional Immunizations Required 2020/2021 School Year Grades 6-12

Rising 6th graders (current 5th grade students) All students who are moving up to the 6th grade in the fall are required to receive a Tdap vaccination when turning 11 years old. Proof of vaccination or proof of an appointment to be vaccinated is required within 30 days of school starting, or within 30 days of your child's 11th birthday, to avoid exclusion from school.

Rising 7th graders (current 6th grade students) All students moving up to the 7th grade are required to receive the first dose of the meningococcal vaccine within two weeks of school starting in the fall. Proof of vaccination is required within 14 days of school starting to avoid exclusion from school.

Rising 12th graders (current 11th grade students) All students moving up to the 12th grade in September are required to receive the second dose of the meningococcal vaccine. Proof of vaccination or proof of an appointment to be vaccinated is required within 30 days of school starting to avoid exclusion from school.

2019-20 School Year New York State Immunization Requirements for School Entrance/At

Fiona Higgins, RN
Cottle School Nurse
higginsf@tuckahoeschools.org
O: (914) 337-6600 x 1282
F: (914) 337-2367

Tuckahoe Middle School/High School Nurse
nurse@tuckahoeschools.org
O: (914) 337-6600 x 1236
F: (914) 337-4126

TUCKAHOE U.F.S.D.
EMERGENCY INFORMATION CARD
(PLEASE PRINT)

Grade_____ Date_____

NAME _____ BIRTHDATE _____

ADDRESS _____ CITY/ZIP _____ PHONE _____

WHERE CAN PARENTS BE REACHED IF NOT AT HOME?

MOTHER'S NAME _____ ADDRESS _____ PHONE _____ CELL/BEEPER _____

FATHER'S NAME _____ ADDRESS _____ PHONE _____ CELL/BEEPER _____

LIST below 2 neighbors/relatives to call in case of emergency.

NAME _____ ADDRESS _____ PHONE _____ CELL/BEEPER _____

NAME _____ ADDRESS _____ PHONE _____ CELL/BEEPER _____

PLEASE FILL OUT AND SIGN THE OTHER SIDE

In case of accident or serious illness Tuckahoe School District will contact the parents or the alternates listed on this card. However, this does not preclude the school from summoning emergency assistance and transporting a child to the hospital emergency room by ambulance if necessary. I will not hold the school district legally or financially responsible for this action.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

Medical Conditions: _____

_____

Allergies: _____

_____

Medications: _____

_____

Please indicate any accidents, illnesses or operations in the past 12 months: _____

_____

Local Physician's Name: _____ Local Dentist's Name: _____

Address: _____ Address: _____

Telephone Number: _____ Telephone Number: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing 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 ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

TUCKAHOE UNION FREE SCHOOL DISTRICT
HEALTH OFFICE
EASTCHESTER, NY 10707

Health History Section

Name:_____ **Grade/Teacher:** _____ **D.O.B.:**_____

Parent Guardian

Please answer the following questions by checking the **YES** or **NO** box. If **Yes,** describe the condition below:

Has your child experienced:

1. Any serious head injury or concussion? **Yes** **No**
2. Any loss of consciousness or a seizure? **Yes** **No**
3. Any chronic illness:
   Asthma_____ **Bleeding disorder**_____ **Diabetes**_____
   High blood Pressure_____ **Allergies**_____ **Heart disease**_____
   High cholesterol_____ **Anemia**_____ **Other**_____
4. Any disease or injury of the following:
   Eyes_____ **liver**_____ **ears**_____ **skin**_____
   Kidneys_____ **joints** _____ **testicles**_____
   Muscles_____ **bones**_____ **nervous system**_____

5. Any injury or illness requiring medical attention? **Yes** **No**
6. Any illness lasting more than 5 days? **Yes** **No**
7. Taking any medication or under a physicians care at this time? **Yes** **No**
8. Wears orthodontic appliance? **Yes** **No**
9. Any teeth capped or replaced? **Yes** **No**
   Started taking a medication regularly? **Yes** **No**
10. Chicken Pox/or had infectious mononucleosis? **Yes** **No**
11. Had any hospitalization surgery or fracture? **Yes** **No**
12. Does your child wear contact lenses or glasses? **Yes** **No**
13. Had a relative who died suddenly before the age of 50? **Yes** **No**
    (i.e. Grandparent, mother , father, brother, or sister)
15. Has your child recently passed out during exercise or stopped exercising because of dizziness or fatigue? **Yes** **No**
16. Has your child ever suffered a heat-related illness? **Yes** **No**
17. Does your child see a physician regularly for a specific problem? **Yes** **No**
18. Is your child allergic to any medications, bee-stings or other allergies?_____ **Yes** **No**
19. Chest pain or exertion?
20. Heart palpitations related to exercise? **Yes** **No**
21. History of Kawasaki Disease? **Yes** **No**
22. History of Lime Disease? **Yes** **No**
23. Diagnosis of Marfans syndrome? **Yes** **No**
24. Diagnosis of Turners syndrome? **Yes** **No**
25. History of malignancy? **Yes** **No**
26. Any condition that may be exacerbated by playing sports? **Yes** **No**
27. Any change in eating habits? Weight gain_____ Weight loss_____ **Yes** **No**

Comments:

Parent/Guardian: I have reviewed the above health history. I hereby certify that the above information is accurate and current and my child does not have any medical condition that would affect participation in sports activities and/or Physical Education classes.

Parent/Guardian Signature:_____

Student's Signature:_____

PLEASE NOTE: Personal appliances such as glasses, contact lenses, braces and/or hearing aids involve a certain degree of risk to your child. Parent/Guardian is responsible for loss or damage to such personal appliances.

TUCKAHOE
UNION FREE SCHOOL DISTRICT

HEALTH OFFICE

TO: Parent/Guardians

FROM: The School Nurse's Office

Re: **School Medication Administration**

If your child needs to take medication, either prescription or non-prescription during school hours, you and your doctor must complete the form attached to this letter. Bring the form and the medication to the school nurse. The medication must be in a properly labeled bottle.

If medication is not properly labeled and we do not have signed parent/doctor consent, we cannot give the medication.

We must work together for the health and well being of our students and your children.

If you have any questions, please do not hesitate to call the Health Office.

Thank you for your cooperation.

Sincerely,

W.E. Cottle Nurse 914-337-5376 ext 1282
TMS/THS Nurse 914-337-5376 ext 1236

Reminders:

Be sure that the doctor completes the form. (The doctor may attach an RX form.)
Prescriptions must be in the original container.
Do not send any pill or liquid to school with your child.
Over the counter drugs must be in original container and must follow the above.

Authorization for Medication(s) to be Taken During School Hours

The following section is to be completed by the PARENT:

School Name: Please circle one: W. E. Cottle TMS THS Grade:

Child's Name: _____ _____ _____
Last First Sex Date of Birth

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to self-medicate her/himself as also authorized by the physician and myself (see below).
Parent/Guardian Signature _____ Date: _____

Home Phone _____ Cell/Work Number: _____

The following is to be completed by the PHYSICIAN:
REASON FOR MEDICATION: _____

NAME OF MEDICATION: _____

FORM: _____

DOSE: _____

If medication is give DAILY, at what time? _____
If medicine to be given WHEN NEEDED, describe indications:
_____
How soon can it be repeated? _____
Is child authorized to self-medicate her/himself? _____
List significant side effects: _____
Length of time this treatment is recommended: _____

OTHER INFORMATION:

_____
_____
_____

Date: _____ Physician Signature: _____

Please print or use stamp.
Physician Name:
Address:
Phone Number: _____

The law allows any person not necessarily a nurse to assist in carrying out a physician's recommendations, and the school recognizes the desirability of responding to the physician's request. This accommodation on the part of the school is not legally required. Therefore, the persons signing this form are agreeing to hold the school and its personnel free from any and all suits that might arise.

Tuckahoe School District
Health Offices

Tuberculosis Screening

Either **A or B *must*** be completed by a physician. If either is ***not*** completed, this form will be returned

Patient's Name _____ Date of Birth _____
(please print)

A).
PPD (Mantoux):

Date placed_____ Date read _____Result in mm ____M.D. initials_____

B). Tuberculin screening is *not* indicated at this time _____
M.D. initials _____

Last PPD on record · Date placed_____ result _____

If test result is positive :

Chest x-ray : Date _____ result _____
INH therapy: yes_____ no ____ Date _____

Additional comments: _____
_____

Physician's signature_____ **Stamp or Print**_____
Date _____ _____

TUCKAHOE
UNION FREE SCHOOL DISTRICT

Mr. Austin Goldberg
Director of Health, PE & Athletics
65 Siwanoy Blvd.
Eastchester, NY 10709

Tel: (914) 337-6600 ext. 1399
Fax: (914) 337-5236
Goldberga@tuckahoeschools.org
www.tuckahoeschools.org

RELEASE TO EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize you to exchange all pertinent and confidential information regarding _____.

(Student Name)

I also authorize a representative of the Tuckahoe School District to speak with and exchange information with the person(s)/organization listed below:

The information may be exchanged with:

Agency/Name: _____

_____

_____

_____

This release has been authorized by:

Signed: _____

Relationship: _____

Date: _____

Release

TUCKAHOE UNION FREE SCHOOL
DISTRICT HEALTH OFFICE

DENTAL HEALTH CERTIFICATE

Parent/Guardian: New York State Law (Chapter 281) permits school's to request a dental examination in the following grades: school entry, K, 2, 4, 7, and 10. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up, ask your dentist to fill out section 2. Return the completed form to the school nurse as soon as possible. ***The date of the exam needs to be within 12 months of the start of the school year in which it is requested.***

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_____Grade: _____

Will this be your child's first visit to a dentist? Yes ____ No ____

Section 2. To be completed by the Dentist

The Dental Health condition of _____ on _____.
(name of student) (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. Please check the following:

_____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.
_____Yes, All necessary dental work for the above student has been *completed.*
_____ Yes, The student listed above is presently *undergoing* dental treatment.

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:

_____

_____