POCANTICO HILLS CENTRAL SCHOOL

Health Forms Information Sheet

February 2018

Grades Pre-K, K, 2, 4, 7 & For All New Students

Dear Parents & Guardians of Pre-K, Kindergarten, Gr. 2, 4, 7 & All New Students:

Please find the following forms in the enclosed packet that you will have to complete or have completed for this school year: **2018 – 2019**

1. **Physical Examination Certificate:** to be completed by your child's physician after having a physical examination.
   By law, all new students and those entering grades Pre-K, K, 2, 4 & 7 must have a physical examination completed by their physician/practitioner. Completed forms, signed and dated by physician anytime within the last 12 months, are acceptable. Your child will be examined by the school physician if we do not have a signed and dated form on file.

2. **Vaccination Administration Record:** to be completed by your child's physician.

3. **Medication Administration Form:** to be completed by your child's physician, **and** you, only if your child will be taking any medication while he or she is at school.

   No student is to bring in or take any medication in school (including inhalers) without a written note from the parent, a doctor's order (written and signed) and a pharmacy labeled container for the medicine. This includes **ALL medications** such as Tylenol, Motrin, cough syrup, etc. All medications are kept locked in the nurse's office. Since medication can cause side effects, please let me know if your child is on any medication at home.

   If your child has asthma, it is a good idea to keep an extra inhaler at the nurse's office. If your child should have an isolated attack, I will then be able to help him/her feel better.

4. **Child Health History Information Form:** to be completed by you.
   The information on this form helps me to ascertain the current health status of your child. I ask that this form be completed annually.

5. **Dental Examination Certificate**: to be completed by your child's dentist.
   This law, effective Sept. 2008, requires students enrolling in Pre-K, K, 2, 4 & 7 in a public elementary school in New York to present a dental health certificate stating a report of a comprehensive dental examination.

Please return all forms to the Health Office as soon as they are completed. Make sure to keep a copy of the forms for yourself, as they are often needed for camp or after school programs. If you have any questions, please call or stop by. Thank you for your cooperation.

Sincerely,
Gay Harmon, RN

ALL FORMS ARE AVAILABLE IN THE HEALTH OFFICE AND ON THE SCHOOL WEBSITE

2/18

Phone: 914-631-2440, ext. 113 Fax: 914-631-2441 Email: gharmon@pocanticohills.org

POCANTICO HILLS CENTRAL SCHOOL

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name: _____ DOB: _____ Gender: ☐M ☐F

School: Grade: ☐N/A Exam Date:

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today: _____

☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma**: ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes**: ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures** Type: _____ Last Occurrence: _____ ☐Emergency Care Plan Attached

☐**Allergies**: ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other: _____

Allergen(s): _____

☐Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____

Treatment prescribed: ☐None ☐Antihistamine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:		**Positive**	**Negative**	**Not Done**	**Date**
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐ One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

Height: **Weight:** **BP:** **Pulse:** **BMI:**

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer: _____

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th- 94th

☐ 5th- 49th ☐ 95th- 98th

☐ 50th-84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes☐No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): **Tanner:** ☐I ☐ II ☐III ☐IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** (please base restrictions/modifications on the following Interscholastic Sports Category

- ☐ **No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
- ☐ **Other Specific Restrictions:**

☐ **Accommodations:**	☐Protective Equipment	☐Sport Safety Goggles	☐Pacemaker
	☐Medical/Prosthetic Device	☐Athletic Cup	☐Insulin Pump/Insulin Sensor
	☐Brace/Orthotic	☐Hearing Aides	☐Other:

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____ _____

_____ _____

MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS REQUESTED BY HEALTH CARE PROVIDER

Independent Use and Carry Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration and parent/guardian permission to allow this option in schools.

☐ **Required Independent Use and Carry Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL - VALID FOR 1 YEAR

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature:

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: _____

Provider Address: _____ Fax #: _____

Return to:

School Nurse: _____ School: _____

Phone #: ( ) Fax: ( ) Date:

POCANTICO HILLS CENTRAL SCHOOL DISTRICT
VACCINATION ADMINISTRATION RECORD

Please return this report to your School Nurse as soon as your child's vaccinations have been given or updated. Obtaining proper vaccinations for your child is required by law and admission to school can be denied without them. District policy requires students provide proof of having had a minimum of one vaccine from each of the series of vaccines below in order to be permitted to enter school.

This form should be completed or updated annually. Please see the list of immunization requirements below:

NAME: _____ DOB: _____ Gr: _____ School year: September: _____

Immunization Requirements:

As required by NY State Dept. of Education, a clinic or physician's verification of the following is needed for school attendance:

- **five (5) or four doses** of diphtheria toxoid containing vaccine **(DTaP, DT, Td)** if the 4th dose was received at 4 years of age or older **(DTaP)**
- **four (4) doses** of polio vaccine **(IPV)** or 3 doses if 3rd dose received at 4 years of age or older
- **two (2) doses** of live measles vaccine♦: 1st dose on or after first birthday; **2nd dose for kindergarten**
- **one (1) dose** of live mumps vaccine♦: administered on or after the 1st birthday
- **one (1) dose** of live rubella virus vaccine♦: administered on or after the 1st birthday
- **three (3) doses** of Hepatitis B vaccine **(HBV)**
- **one (1) dose** of varicella (chicken pox) vaccine. **2nd dose for kindergarten and grades 1,2,3,6,7,8 and 9**
- **In addition, for pre-kindergartners:**
  - Haemophilis influenzae type b vaccine **(Hib): three (3) doses, or one (1) dose after 15 months of age**
  - Pneumococcal conjugate **(PCV)** vaccine for those born on/after 1/1/08: **four (4)** doses by 15 months of age given at age-appropriate times & intervals

For students entering 6th Grade:
  - **One (1)** dose of tetanus toxoid, diphtheria and acellular pertussis vaccine **(Tdap)** for students born after 1/1/94 entering 6th, 7th or 8th grades
  - **Two** (2) doses of Varicella (chickenpox) vaccine

For students entering 7, 8 and 12th grades: One dose (1) of Meningoccal vaccine, gr 7 & 8, **Two** doses for grade 12

♦ MMR is preferred vaccine

VACCINATION ADMINISTRATION RECORD
TO BE COMPLETED & SIGNED BY PHYSICIAN/PRACTITIONER:

VACCINE	DATE GIVEN:	VACCINE	DATE GIVEN:
DTaP 1	DTaP 3	HEP B 1	
DTaP 2	DTaP 4	HEP B 2	
DTaP 5	OR...	HEP B 3	
DT 1	OR Td 1	OR (Adult formulation 2 dose series, ages 11 – 15 yrs)	
DT 2	OR Td 2	HEP B 1 (1.0 ML)	
DT 3	OR Td 3	HEP B 2 (1.0 ML)	
Tdap		HIB 1	HIB 3
IPV 1	IPV 3	HIB 2	HIB 4
IPV 2	IPV 4	LEAD LEVEL	RESULT
VARICELLA VACCINE		PNEUMOCOCCAL VACCINE	
VARICELLA VACCINE BOOSTER		1	2 3 4
MMR 1		PNEUMOCOCCAL VACCINE (PCV13)	
MMR 2		MENINGOCOCCAL VACCINE	
TST (LAST) MANTOUX	RESULT ❖	HEP A 1	HEP A 2
BCG		HUMAN PAPILLOMAVIRUS VACCINE (HPV)	
		1	2 3
		OTHER	

❖ If Positive TST, Chest x-ray needed:
Date of CXR: _____ Results: _____
INH started: _____ X _____ months

OFFICE STAMP NECESSARY HERE

Physician/Practitioner's Name:
(Print) _____

Address: _____

City/State/Zip: _____

SIGNED: _____

Telephone #: _____

Date of Completion: _____

POCANTICO HILLS CENTRAL SCHOOL

Permission to Administer Multiple Medications

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

To Be Completed By Health Care Provider

Diagnoses _____

Medication Name	Dose	Route	Time	☑ applicable boxes below
				☐ AM _____ ☐ Bus ☐ FT ☐ SSA ☐Self-Directed ☐ Self Admin-Self Carry
				☐ AM _____ ☐ Bus ☐ FT ☐ SSA ☐Self-Directed ☐ Self Admin-Self Carry
				☐ AM _____ ☐ Bus ☐ FT ☐ SSA ☐Self-Directed ☐ Self Admin-Self Carry

Prescriber please use codes below for each medication ordered:

AM	Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication
Bus	Medication must be available on bus
FT	Medication is needed on field trips
SSA	Medication is needed school sponsored extra-curricular activities
Self-Directed	I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.
Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____ **Date** _____ **Phone** _____

Stamp:

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature _____ **Date** _____ **Phone** _____

Self-Administer/Self Carry

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature _____ **Date** _____ **Phone** _____

School Nurse: Gay Harmon RN

Phone: 914-631-2440, ext. 113 Fax: 914-631-2441 Email: gharmon@pocanticohills.org

POCANTICO HILLS CENTRAL SCHOOL

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes:_____

Please list any additional concerns: (use back of sheet if necessary)_____

_____

Parent/Guardian Signature:_____ Date:_____

1/2018

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 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. 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 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 dental health condition of _____ _____ on_____ (date of assessment)
The date of the assessment 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/ Dental Hygienist's name and address

(please print or stamp) **Dentist's/Dental Hygienist'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):_____

II. 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.