TRINITY ELEMENTARY SCHOOL
OF COMMUNICATION ARTS & TECHNOLOGY
180 PELHAM ROAD
NEW ROCHELLE, NEW YORK 10805-3197
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TRINITY ELEMENTARY SCHOOL

Health Forms

Dear Parents/Guardians:

Enclosed are the health forms **necessary** to register your child at Trinity Elementary School. In addition, you must bring to school the most recent immunization record. Without the list of immunizations we **cannot** begin registration.

Here is a list of what to bring to the nurse at registration.

- Most recent immunization record
- Report of recent physical exam, ***mandatory*** for all new students, and all students entering K, 2nd and 4th grade.
- Medical History Form, which is completed by you, the parent or guardian, and reviewed with the nurse when you come to school.
- Dental certificate

Any questions, please call us at ***576-4663.***

Sharon DeGeorge, R.N.
Nora Klion-Wolloch, R.N.

Out of Distric (K-5)
May 2017

HEALTH SERVICES
CITY SCHOOL DISTRICT OF NEW ROCHELLE

Adrienne Weiss-Harrison, M.D. Medical Director

Early Childhood School Health History

Date form completed: _____ [ ]Parent Completed [ ]In Person Interview [ ]Telephone Interview

School: _____ Grade: _____

General Information:

Child's Name: _____ Sex: ☐M ☐F DOB: ___/___/___ Age: _____

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____ Office Phone: _____ Parent email: _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

Brothers and Sisters Names:

1. _____ Sex: ☐M ☐F Date of Birth: ___/___/___
2. _____ Sex: ☐M ☐F Date of Birth: ___/___/___
3. _____ Sex: ☐M ☐F Date of Birth: ___/___/___
4. _____ Sex: ☐M ☐F Date of Birth: ___/___/___

Are parents: ☐Married ☐Divorced ☐Separated ☐Remarried ☐Single

Who cares for the child after school: _____

Birth History:

Birth weight: ___ lbs. ___ oz. Weeks gestation: ____ Hospital born at: _____

Pregnancy: ☐ Normal ☐ Complications: _____

Type of delivery: ☐ NSVD ☐C-Section ☐Breech ☐Forceps ☐Other
Reason: _____

Problems during pregnancy: _____

Problems during delivery: _____

Problems after delivery: _____

If NICU, add details:

Respiratory/Cardiac:

Ventilator: ☐No ☐ Yes If yes, # _____days _____weeks

Cardiac Surgery: ☐No ☐ Yes If yes, describe, including age at surgery: _____

_____

Other: _____

_____

GI/GU:
Describe, including any feeding problems: _____
_____

Infection: _____
Neurology:
Intraventricular Hemorrhage: ❒No ❒ Yes If yes, Grade: [ ] I [ ] II [ ] III [ ] IV
_____
Ophthalmology:
Retinopathy of Prematurity: ❒No ❒ Yes If yes, current vision/vision care: _____
_____
Neonatal Hearing Test (OAE): [ ] Normal [ ] Abnormal If abnormal, current hearing level and care: _____

Specialist and Subspecialist practitioners involved with child during neonatal/infancy period:
Specialist 1: _____ Phone _____ Address _____
[specify specialty]
Specialist 2: _____ Phone _____ Address _____
[specify specialty]

Developmental History:
At what age did this child?

Roll over	_____	months
Sit up without support	_____	months
Crawl	_____	months
Walk alone	_____	
Talk (two words together)	_____	
Bladder trained	_____	
Bowel trained	_____	

Did your child experience feeding difficulties during infancy?
If yes, please describe: _____

Did your child have any sleep problems during infancy?
If yes, please describe: _____

What was your child's temperament during infancy: _____
_____

What was your child's temperament as a toddler: _____
_____

Early Intervention Program
Did this child have EI services: ❒No ❒ Yes
If yes: Age at which services began: _____ months _____ years
Services: ❒Speech ❒ OT ❒PT ❒ SEIT ❒Other, specify: _____
Frequency of services: _____

Past Medical History:
Allergies to food or medicines? ❒Yes ❒ No Name of allergens: _____

If yes, please describe: _____

_____
(If yes, complete allergy history for registration)
Immunizations up to date? If not, please elaborate: _____

_____

Medications (including name, dosage and frequency) taken:
1. _____
2. _____
3. _____

Hospitalizations, accidents or broken bones (note any ICU admissions)

Date	Child's Age	Name of hospital	Reason for hospitalization
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

Major or serious illnesses

Date	Child's Age	Illness	Physician	Treatment
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____

Surgical procedures (do not repeat information from neonatal history):

Date	Child's Age	Physician	Procedure
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

Review of Systems:

Indicate which of the following conditions or problems the child has had. Give details and dates for the problems checked:

[ ]Skin trouble
[ ]Eye or vision problems]
[ ]Eyeglasses
[ ]Frequent ear infections
[ ]Difficulty hearing
[ ]Frequent nose bleeds
[ ]Nasal allergies]
[ ]Sinus problems
[ ]Frequent sore throats
[ ]Thyroid problems
[ ]Pneumonia
[ ]Asthma
[ ]Any other lung problems
[ ]Heart murmur
[ ]Any other heart problems
[ ]Jaundice
[ ]Frequent stomach aches
[ ]Frequent diarrhea
[ ]Frequent constipation
[ ]Black or tarry stools
[ ]Kidney or bladder infection
[ ]Frequent or painful urination
[ ]Bedwetting
[ ]Joint aches or pains
[ ]Orthopedic or bony problems
[ ]Seizures
[ ]Frequent headaches
[ ]Skin rashes
[ ]Insect bite reactions
[ ]Anemia
[ ]Speech problems
[ ]Increased lead levels
[ ]Current health concerns/issues

Girls: Menstrual History
Onset: _____
Frequency: _____
Cramps: ☐ Yes ☐ No
Irritability: ☐ Yes ☐ No
Other: _____

[Note any important details in the space below.]

Current Practitioners:

Pediatrician/FP/NP: _____ Phone _____ Address _____

Specialist 1: _____ Phone _____ Address _____
[specify specialty]

Specialist 2: _____ Phone _____ Address _____
[specify specialty]

Specialist 3: _____ Phone _____ Address _____
[specify specialty]

Specialist 4: _____ Phone _____ Address _____
[specify specialty]

Behavioral History: Has your child ever been evaluated for, diagnosed with, or treated for:

1. ADHD [ ]Yes [ ]No
2. Anxiety Disorder [ ]Yes [ ]No
3. Tourette's Syndrome [ ]Yes [ ]No
4. Depression [ ]Yes [ ]No
5. OCD [ ]Yes [ ]No
6. Other _____

Details: (Including psychiatric hospitalizations) – If using separate sheet please check here [ ]

_____

_____

_____

_____

Name of Evaluating/Treating Physician\Psychiatrist\Psychologist

Physician Name _____ Telephone _____ FAX _____

Street Address _____ City _____ ST ____ Zip ____

Pediatrician/FP/NP: _____ Phone _____ Address _____

Specialist 1: _____ Phone _____ Address _____
[specify specialty]

Specialist 2: _____ Phone _____ Address _____
[specify specialty]

Family History:

Father's country of birth: _____ Mother' country of birth: _____
Father's occupation: _____ Mother's occupation: _____
Father's Education: _____ Mother's Education: _____

Does the child have any blood relatives (father, mother ,brother, sister, father's side or mother's side who have the following conditions? (mark with a check)

[ ]Birth deformity _____
[ ]Mental retardation _____
[ ]Convulsions, epilepsy _____
[ ]Mental illness _____
[ ]Family or inherited disease _____
[ ]Death in childhood _____
[ ]Eye problems _____
[ ]Hearing Problems _____
[ ]Asthma _____
[ ]Hay fever _____
[ ]Allergies _____
[ ]Severe Anemia _____
[ ]Sickle Cell disease _____
[ ]Bleeding tendencies _____
[ ]Tuberculosis _____
[ ]Diabetes _____
[ ]Heart Attack (under age 50) _____
[ ]Cancer _____
[ ]High blood pressure _____
[ ]Kidney problems _____
[ ]Obesity _____
[ ]Thyroid Problems _____
[ ]ADD/ADHD _____
[ ]Speech issues _____
[ ]Developmental delay _____
[ ]Learning disability _____
[ ]Autism _____

For all conditions checked please describe: _____

_____

Educational History:

Previous School: _____ Location: _____Length of Attendance: _____

If not in New Rochelle: Has your child ever attended school in New Rochelle? [ ]Yes [ ]No

If yes, please list the schools and circle the name of the last school your child attended in New Rochelle.

_____ _____

_____ _____

Did your child have an? IEP [ ]Yes [ ]No 504 Plan [ ]Yes [ ]No

Did your child receive any services at previous school? [ ]Yes [ ]No If yes please describe: _____

_____

Social History:

Living situation: ❒ Homeowner ❒ Home rental
❒ Apartment owner ❒ Apartment rental

Who lives in the home? _____

Does child have: Own room ❒ Yes ❒ No Own bed ❒ Yes ❒ No

Pets in the home? ❒ Yes ❒ No If yes, specify: _____

Does anyone smoke in the home? ❒ Yes ❒ No

First language of child: _____ Language spoken at home: _____

_____
Signature of School Nurse Date

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and Annual & Program Reviews and Reevaluations for the Committee on Special Education (CSE)

*****PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

City School District of New Rochelle – Health Services Department

HEALTH APPRAISAL FORM Date of Exam: ___/___/___

Name: _____ **Date of Birth:** ___/___/___ **Gender:** ❑ M ❑ F

School: _____ **Grade:** ____

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal: (include dates)

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: _____
PPD: Please complete screening on reverse side of form
Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: _____
Dental Referral ❑ Yes ❑ No ❑ Not done Date: _____

Significant Medical/Surgical History: ❑ See attached _____

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension ❑ Other: _____

Allergies: ❑ LIFE THREATENING ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ _____ . _____ (Required by NYS)

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ Pass 20 db sc both ears or:	R	L	

❑ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❑ Negative ❑ Positive: _____
For Girls: Age of onset of menses: _____ LMP: _____
Specify any abnormality (use separate paper if needed): _____

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
❑ **Specify medical accommodations needed for school:** _____ ❑ None
❑ **Known or suspected disability:** _____ ❑ Please monitor
❑ **Restrictions:** _____ ❑ Please monitor
❑ **Protective equipment required:** ❑ Athletic Cup ❑ Sport goggles/impact resistant eyewear ❑ Other: _____

SPORTS CLEARANCE : By signing and submitting this form, the parent and physician attest that they have fully disclosed all of this student's health history, conditions, medications and relevant family history (e.g., early cardiac death.) Parent and physician assume liability for non-disclosures of such information. The School District Physician has final authority to medically clear students for interscholastic sports participation. Parental signature authorizes School Health personnel to communicate with your child's physician regarding medical clearance for sports.

Provider's Signature: _____ **Phone:** _____

Provider's Name/Address: _____ **Fax:** _____

*****Parent Signature:** _____ **Date:** _____

H-1 HEALTH APPRAISAL FORM (Revised 2/08)
This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

*****PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM**

TUBERCULOSIS TESTING / SCREENING – EITHER A OR B MUST BE COMPLETED BY THE PHYSICIAN

A. PPD (Mantoux):

1. Date placed _____ Date read _____ Result in mm _____
2. If PPD is Positive: CXR: Date of exam: ____/____/____ Result: _____

Treatment: _____

_____

B. Tuberculin screening not indicated _____ (MD must initial)

PRESCRIPTION MEDICATIONS

Medications (list all): ❒ None

Medication: _____ Dosage/Time: _____

Medication: _____ Dosage/Time: _____

Medication: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❒ Yes ❒ No *Student may self carry and self administer medication ❒ Yes ❒ No

Note: Nurse will also assess self-direction for the school setting. ***Students are not permitted to carry or self-administer USDEA controlled drugs.** Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PERMISSION TO RECEIVE PRESCRIPTION AND OVER THE COUNTER (OTC MEDICATION)
Health Care Provider and Parent signatures required
Parents must provide all medications.

❒ Tylenol (pain, fever)	Dose _____	Freq._____	Route_____
❒ Ibuprofen (Advil, Motrin) (pain, fever)	Dose _____	Freq._____	Route_____
❒ Benadryl (Allergic reaction/Allergy)	Dose _____	Freq._____	Route_____
❒ Antacid (Maalox, Tums) (abdominal discomfort)	Dose _____	Freq._____	Route_____
❒ Cough Drops/Throat Lozenges (sore throat)	Dose _____	Freq._____	Route_____
❒ Antibiotic Ointment (skin lesions)	Dose _____	Freq._____	Route_____

SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE TO DISPENSE PRESCRIPTION AND OTC MEDICATION

(Stamp below)

Provider's Signature: _____ **Phone:** _____

Provider's Name/Address: _____ **Fax:** _____

*****Parent Signature:** _____ **Date:** _____

Parental signature authorizes School Health personnel to communicate with your child's physician regarding prescription and OTC medication.

HEALTH OFFICE
TRINITY ELEMENTARY SCHOOL
180 PELHAM RD
NEW ROCHELLE, N.Y. 10805-3197
914-576-4663
FAX - 914-576-4266

DENTAL HEALTH

Trinity Health Office 180 Pelham Road New Rochelle, NY 10805
Phone (914) 576-4663 Fax (914) 576-4266

To All Parents: If your child has not had a dental exam within the past year, please call today and schedule an appointment.
People can keep their teeth throughout life if they do their part and allow the dentist to do his or her part. Most dental disease is preventable.

Starting at age 3 regular visits to the dentist are essential. During a dental visit the dentist will:

1. Examine teeth and gums.
2. Clean teeth.
3. Check teeth for cavities and fill them while they are small.
4. Prevent major dental problems.
5. Provide dental health instructions.

A Todos Los Padres y Guardianes: Si su nino o nina no ha sido examinado por el dentista durante el ano pasado, favor de llamar hoy hacer una cita para esta proposito.
Las personas pueden mantener sus dientes por todo la vida – si ponen de su parte le dan oportunidad al dentista de ayudarles. La mayoria de las enfermedades dentales se pueden evitar.

Empezando al trecer ano las visitas al dentist son recomendandol. Durante la vista el dentista le prestara los siguentes servios:

1. Examina los dientes y las encias
2. Le limpia los dientes
3. Examina sus dientes para averiguar si caries, en cuyo caso las mismas son llendas. Es mejor cuidarse de las cuando estas son pequenas.
4. Ayuda a prevenir mayores problemas de dentales.
5. Provee instruccciones para la salud dental.

Please have your Dentist fill out the form below and return to school.
Pidale al dentista que completa la forma adjunta y devuela la misma a la enfermera escolar.

School:_____ Teacher:_____ Grade:_____

Child's Name:_____

The above child has had a dental examination and the necessary work is:

Completed _____in Process_____ Did you recommend orthodontia? Yes___ No___

_____
Dentist's Signature Date

Trinity Health Office Policy Save for Future Reference
Nurse's Phone 576-4663

ABSENCES: Call the Trinity School Office at 576-4440 each time your child is absent. Please report contagious diseases so we can send health alerts with his/her classmates.

ILLNESS: Children must stay home if they are sick, have a temperature, diarrhea, or rash or vomiting. Children with contagious conditions such as pink eye, strep throat, or lice cannot come to school without medical treatment and a note from the doctor. **Children must stay home until their temperature has been normal (under 100.0) for 24 hours with out being given Tylenol or Advil.**

INJURIES and GYM EXCUSES: New York State law requires that a school nurse have a note which explains large bruises, cuts or stitches from injuries received outside school. Children who have stitches, broken bones, serious injuries or hospitalizations must have a doctor's note giving the child permission to return to school and state if your child can take gym. Only a doctor can give permission to be excused from gym for any reason.

EMERGENCY CARDS: They are filled out at the beginning of each school year. We must be able to contact a parent at all times when a child becomes sick or injured at school. It is the parent's responsibility to make sure that the numbers on the card are correct. Any changes should be sent to the Nurse. When parents cannot be reached, friends and relatives listed on the card give the school permission to call another adult to pick a child up. Sick children must go home.

MEDICATIONS: Medications given in school follows New York State Law. This policy is for **prescription and non-prescription** drugs such as Tylenol or cold medications. All medications are to be kept in the Nurses Office. The **physician** must write a specific order for the medication to be given in school. **Children may not carry medicine on their person without permission.**

- Directions must include, the dosage and time must be given.
- The parent must give written permission to follow the doctors order
- Medication must be brought to the Nurse by the parent in an ORIGIONAL labeled container from the pharmacy.

Ask the Nurse for more information if medication is needed on a trip.

NEBULIZER: A nebulizer is available for asthmatic children. The doctor must write an order as described above. Parents supply the mask, medication chamber and medicine.

PHYSICALS: New York State Law requires that all children have a physical examination when entering school, K, 2nd, 4th grade. The completed report of the examinations is due by October 15, and should include blood pressure, height, weight, proof of new immunizations, and information about any health problems. We recommend an annual physical each year a child is in Trinity School, so that we know they are able to participate in all activities.

VISION AND HEARING TESTS: All children have a hearing and vision screening each year. Parents will be notified if there is a need for further testing.

CLOTHING AND SHOES: Children are active during the day, need to dress appropriately for participating in school activities. We recommend sneakers daily for both boys and girls. Make sure your child can zip, button, and tie so they are safe and able to use the bathroom independently.