TRINITY ELEMENTARY SCHOOL
OF COMMUNICATION ARTS & TECHNOLOGY
180 PELHAM ROAD
NEW ROCHELLE, NEW YORK 10805-3197
TEL: (914) 576-4440
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INTERIM SUPERINTENDENT OF SCHOOLS

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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.

October 2018

CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

STUDENT HEALTH HISTORY

Name:	**DOB:** **Age:** **Grade:**	**Gender:**
Parent/Guardian Name:	**Home Phone:** **Cell:** **Email:**	**Date:**

Your Child's Medical History	**YES**	**NO**	**If Yes, please explain and include date:**
Born premature or had complications after birth	☐	☐	
Has an ongoing medical or developmental condition	☐	☐	
Sees a medical specialist	☐	☐	
Has severe **allergies** or **anaphylaxis**	☐	☐	☐Food ☐Environmental ☐Insect ☐Medication ☐Other Specify:
Has been hospitalized	☐	☐	
Had an operation/required surgery	☐	☐	
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, has a **seizure disorder**, or **epilepsy**	☐	☐	
Has a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Has a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Wears a 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
☐ Allergies
☐ Asthma
☐ Autism
☐ **Diabetes**
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Condition
☐ High Blood Pressure
☐ Mental Health Condition (Depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis/Orthopedic Impairment
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition
☐ EI/CPSE/CSE services_____

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:

Parent/Guardian Signature: _____ **Date:** _____

CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

HISTORIA DE SALUD DEL ESTUDIANTE

Nombre:	**Fecha de Nacimiento:** **Edad:** **Grado:**	**Sexo:**
Nombre del Padre/Tutor legal:	**Tel. de casa:** **Celular:** **Correo electrónico:**	**Fecha:**

Historia clínica de su hijo/a	**SI**	**NO**	**Si la respuesta es SÍ, explique e incluya la fecha**
Nació prematuro o tuvo complicaciones después del nacimiento	☐	☐	
Tiene una enfermedad médica o de desarrollo	☐	☐	
Ve a algún especialista	☐	☐	
Tiene **alergias** severas o **anafilaxia**	☐	☐	☐Comida ☐Ambiental ☐Insectos ☐Medicina ☐Otra Especifique:
Ha sido hospitalizado	☐	☐	
Tuvo una operación/cirugía requerida	☐	☐	
Tuvo una lesión que requirió visitar la sala de emergencia	☐	☐	
Faltó a la escuela por 5 días consecutivos debido a una enfermedad o lesión	☐	☐	
Tuvo una lesión muscular u ósea	☐	☐	
Se desmayó, tuvo una conmoción cerebral o lesión grave en la cabeza	☐	☐	
Tuvo una convulsión, tiene un trastorno convulsivo o epilepsia	☐	☐	
Tiene un problema o condición de la vista	☐	☐	☐ lentes o gafas ☐ lentes de contacto
Tiene un problema o condición auditiva	☐	☐	☐ dispositivo auditivo ☐ implante cochlear
Usa un puente, frenos, boquilla (protector), dentales	☐	☐	
Algún miembro de la familia menor de 50 años:	**SI**	**NO**	**Si la respuesta es SÍ, especifique:**
Tuvo un ataque cardiaco	☐	☐	
Han tenido otros problemas de salud serios	☐	☐	

MARQUE TODO LO QUE LE APLIQUE A SU HIJO/A

☐ ADHD (Trastorno por Déficit de Atención con Hiperactividad)
☐ Alergias
☐ Asma
☐ Autismo
☐ **Diabetes**
☐ Infecciones del oído
☐ Condiciones Gastrointestinales (úlceras, reflujo, síndrome del intestino irritable)
☐ Dolores de cabeza/migrañas
☐ Problemas cardiacos
☐ Alta presión
☐ Problemas de salud mental (Depresión, Desorden Alimenticio, Ansiedad, Desorden Obsesivo Compulsivo, Trastorno de Oposición Desafiante, etc.),
☐ Escoliosis/Discapacidad Ortopédica
☐ Único Órgano (☐riñón, ☐testículo)
☐ Problemas de la Piel
☐ Problemas del Habla
☐ Problemas urinarios
☐ Intervención Temprana/Comité Preescolar de Educación Especial/Comité de Educación Especial servicios_____

MEDICAMENTOS ACTUALES	**SI**	**NO**	**Indique el nombre, la dosis y el horario**
Administrados en la escuela	☐	☐	
Administrados en casa	☐	☐	
EQUIPO DE ASISTECIA	**SI**	**NO**	**Por favor marque todos los que apliquen**
Durante o fuera de la escuela	☐	☐	☐muletas ☐andadera ☐silla de ruedas ☐otro:
TRATAMIENTOS	**SI**	**NO**	
Durante o fuera de la escuela	☐	☐	☐insulina/supervisión de la glucosa sanguínea ☐inhalador/nebulizador/Supervisión del flujo espiratorio máximo ☐dieta especial

¿Hay alguna condición que impida que su hijo/a participe en educación física o deportes?
☐ No ☐ Si: _____
Por favor enumere cualquier preocupación adicional:

Firma del Padre/Tutor legal: _____ **Fecha:** _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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 ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached

☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached

☐ Yes, indicate type ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **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:

Diagnoses/Problems (list)	ICD-10 Code

☐ Additional Information Attached

Name:	DOB:

SCREENINGS

Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

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

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

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

Provider Name: *(please print)* Stamp:

Provider Address:

Phone:

Fax:

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

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.

Las Normas de la Oficina de la salud Salve para la Referencia Futura El Teléfono del enfermera 576-4663

LAS AUSENCIAS: Informa cada vez que su niño está ausente. Llame el de Officino de la Escuela Trinity en 576-4440. Sepamos por favor acerca de enfermedades contagiosas tan nosotros podemos mandar hogar las alarmas de la salud con su compañero de clase.

LA ENFERMEDAD: Niños deben permanecer hogar si ellos están enfermos, tiene una temperatura, la diarrea, o el sarpullido o vomit. Los niños con condiciones contagiosas ojo tal como rosa, con strep, no puede venir a la escuela sin el tratamiento médico y una nota del doctor.Los niños deben permanecer hogar hasta que su temperatura haya sido normal (bajo 100.0) por 24 horas con fuera ser dado Tylenol o Advil. LAS HERIDAS y el GIMNASIO DISPENSAN La ley del Estado de nueva York requiere que un enfermero de escuela tiene una nota que explica las maquiladuras grandes, los cortes o las puntadas de heridas escuela exterior recibida. Los niños que han roto huesos, las heridas o hospitalizations graves debe tener una nota de doctor dar el permiso de niño para estar en la escuela y el estado si su niño puede tomar gimnasio. Sólo un doctor puede dar el permiso para ser dispensado del gimnasio para cualquier razón.

LAS TARJETAS DE LA EMERGENCIA: Ser llenado a principios de cada año de escuela. Debemos ser capaces de avisar a un padre siempre cuando su niño se enferma o herido en escuela. Es el padre responsabilidad de cerciorarse que los números en la tarjeta son correctos Cualquiera cambia debe ser mandado al El enfermero. En caso de que padres no puedan ser capaces de ser alcanzado inmediatamente los números de amigos o parientes listaron en La tarjeta da el permiso de escuela para llamar otro adulto a escoger a un niño arriba. Los niños enfermos deben ir a casa.

MEDICATIONS:Medications se rindió escuela Sigue Nueva York la Ley del Estado. Todo medications deberá ser mantenido en la Oficina de Enfermeros El médico debe escribir una orden específica para el medicatíon para seser rendida escuela. Las direcciones deben incluir, la dosis y el tiempo se deben dar. El padre debe dar el permiso escrito para seguir la orden de doctore. Medication debe ser traído al Enfermero por el padre en un ORIGIONAL marcó contenedor de¡ La farmacia. En ningún tiempo puede a niños llevan la medicina en su persona. Los arreglos especiales pueden ser causados medication para ser dado en viajes. Pregunte al Enfermero para más información.

NEBULIZER: Una de nebulizer está disponible para niños de asthmatic. El doctor debe: la Ley para probar adicional. FISICO es debido por el octubre 15, y debe incluir la presión de sangre, la altura, el peso, la prueba de inmunizaciones nuevas, y de la información acerca de cualquier problemas de la salud.

Fisico INMUNIZACION Las leyes de New York nos requieren manter records de inmunizacion para cada una de los niños. Su niño debe tener un examen medico antes de entrar a la escuela y cada año. Los formularios medicos completos de beran ser devueltos a la escuela antes del 15 de Octubre y debe incluir la precion, la altura, el peso, prueba de vacunas neuvos y informacion acerca de cualquier problemas. Esta nota debe espesificar si esta restriccion es solo para educacion fisica o para las actitades a la hora de Almuerzo.

LA VISION Y LAS PRUEBAS que oyen: Todos niños tienen una selección de oír y visión cada ano. Los padres seran notificados si hay una necesidad para probar adicional.