

Jericho Health Office
Tel 516 203- 3600 Fax 516 203-3626

Dear Parents/Guardians

The New York State Law requires **all new entrants must have the following on file:**

*** NOTE; They are specific immunizations requirements for each grade level. Please see the information in the district calendar.**

1. Proof of Complete Immunizations- copy of the original immunization records must be signed and stamped by a health care provider.

2. Proof of Physical Exam dated from the current year.

Physical exam must be completed, signed and stamp by a NY State health care provider; a physician, a physician assistant or a nurse practitioner. (Body Mass Index (BMI) and Weight Status Category must be included in your child's physical)

3. Proof of Dental Exam completed by a dentist. The NY State Department of Health recommends students have a dental exam from the current year.

4. Health History

Please contact the Health Office if you have any questions.

Seaman Health Office
516-203-3600 ext. 5284

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: <input type="checkbox"/> M <input type="checkbox"/> 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	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g}/\text{dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> 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/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain				
<input type="checkbox"/> Brace*/Orthotic		<input type="checkbox"/> Colostomy Appliance*		<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*		<input type="checkbox"/> Medical/Prosthetic Device*		<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment		<input type="checkbox"/> Sport Safety Goggles		<input type="checkbox"/> Other:
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

Jericho Public Schools
99 Cedar Swamp Road
Jericho, NY 11753
Health Office

Dear Parent /Guardian,

The NY State Department of Health recommends students have an annual dental exam. Please have your dentist complete the form and return it to the Health Office.

Dental Health Certificate

Name _____ Grade _____

Address _____

Exam Date _____

Please check one:

_____ No treatment is necessary
_____ Treatment is in process
_____ Treatment is complete.

Dentist's signature/ stamp

Address

JERICO UNION FREE SCHOOL DISTRICT

Authorization for Administration of Medication in School

A. To be completed by the Parent or Guardian:

I request that my child _____ grade _____, receive the medication as prescribed below by a NYS licensed health care prescriber. The medication must be handed in to the nurse, properly labeled in the original container from the pharmacy. I understand that the school nurse or other designated staff member will administer the medication.

Signature of Parent or Guardian: _____

Address: _____

Telephone #: _____ Date: _____

B. To be completed by the NYS licensed Health Care Prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed dosage, time and route of administration _____

Possible Side Effect and Adverse Reactions: _____

Students can self- carry and self-administration: _____

Name and title of licensed prescriber (please print): _____

Signature: _____ Stamp: _____ Date: _____

Address: _____ Phone: _____

Hearing-Students in grades K, 1, 3, 5 and all new entrants regardless of grade are screened for hearing.

Scoliosis-Scoliosis screenings are performed on all female students in grade 5.

In the event that your child has difficulty with any of the screenings a written notice will be sent to your home for follow up with your private physician.

Physical Exams/Health Appraisals

Students in grades K, 1, 3, and 5 as well as all new entrants to Seaman School are required to have a physical exam by your physician. The examination is due in the Nurse's Office within 30 days of the start of the school year.

If you have not sent in a physical within the 30 days, you will be notified by e-mail with instructions to follow in order to be in compliance with the New York State mandate. We are aware of the insurance rule that only one physical may be given in a year. The form that will be in the e-mail has a place to indicate when your appointment will be.

If your student is not in compliance by the First of the New Year, a physical will be scheduled with our school doctor.

Physical Education Excuses

When a child can not participate in gym due to an unforeseen injury or illness, the following procedure takes place:

1. A doctor's note should be presented to the nurse indicating the disability and length of time a child will be out of gym and recess. If the note does not indicate a date to return, a second note will be

necessary prior to the student's return to gym and recess.

2. A parent may submit a note to excuse a child for **one** day. The Nurse, at her discretion, may extend the excuse for up to one week. After that period of time, a note from the physician is required to be excused.
3. Any student who arrives in school with sutures, a cast, sling, splint or ace bandage is automatically excused from gym and recess. A doctor's note is required to return to gym.
4. Any student who needs to be non-weight bearing (on crutches) during the school day will be given a wheelchair for their use during school. **Children who are on crutches are not permitted on the regular school bus for safety reasons.** Please contact Mrs. Britvan for instructions.

Registration Procedure

All new entrants to the Jericho UFSD are required to have proof of residency which must be a current tax bill, deed, or current lease, signed notarized proof of residency form, original birth certificate as well as documentation of all required immunizations signed by a physician.

The immunizations are; 4 or 5 DTaP (the last being after age 4), 4 Polio (the last being after age 4), 3 Hepatitis B (3rd Hep B given at at least 24 weeks of age), 2 MMR (measles, mumps, rubella), and 2 Varicella. The MMR and Varicella **must** be given on or after the child's first birthday.

All forms and instructions are available on the school website.



ROBERT SEAMAN ELEMENTARY SCHOOL

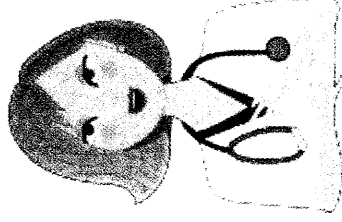
School Nurse

Tele: 203-3600 ext. 5284

Fax: 681-9493

vbritvan@jerichoschools.org

**"EVERY CHILD NEEDS A
SCHOOL NURSE"**



School nursing involves so much

more than Band-Aids!



School Nurses are a vital link in the school team to coordinate and provide care for our students. School Nurses manage diabetes, asthma, life threatening allergies, mental and emotional illness, safety issues, administer medications and provide an endless list of services to our student's on a daily basis.

School Nurses:

- Triage student health concerns
- Assess physical and emotional issues
- Provide primary healthcare to students and staff
- Counsel students, staff and parents on health issues
- Administer medication on a daily and as needed basis
- Refer health issues to healthcare providers for further care and treatment as needed
- Provide health screenings-vision, hearing and scoliosis per New York State Regulations
- Monitor health appraisals (physicals) for NYS mandated grades of K, 1st, 3rd, and 5th, as well as all new entrants
- Write emergency action plans as well as Individual Classroom Healthcare Plans
- Teach students to manage their own healthcare concerns
- Act as a liaison between the home and healthcare provider

School Nurses provide students with what they need in order to be at school and participate in the learning experience!

When your child is ill:



If your child should become ill or injured in school, every effort is made to contact a parent prior to going to the emergency contacts. If a reasonable amount of time passes without being able to get in touch with a parent, the emergency contacts are then notified. **It is extremely important that your personal contacts, including your cell phone and work numbers are kept up to date as well as any changes in your emergency contacts. Students will not be released to any individual who is not listed on the emergency contact list.**

In the rare case your child is seriously injured or ill and a parent is unavailable, please know that your child's health and safety will always be our number one priority!

When your child is home ill, he or she must remain home until their fever is below 100 degrees without the use of any fever reducing medication such as Tylenol, Advil or ibuprofen for 24 hours.

They should also remain home until they are symptom free for 24 hours. For example, if your child has had a stomach virus, they should remain home until all symptoms have resolved and they are eating a regular diet.

Please feel free to contact the Nurse's office for any questions you may have.

Medications in School

Every effort should be made to administer medications outside the school setting. In the event that a student needs medication in school in order to maintain an optimal state of health, the following procedure must be followed:

1. A signed doctor's order stating the name, dosage, time to be given and diagnosis must be on file. This order must be renewed annually. (Forms are available on the school website or in the Nurse's office). This includes over the counter medications as well as prescription medications.
2. Written permission from the parent or guardian authorizing the administration of the medication in school.
3. All medications **must** be brought to school by a parent or other designated adult. No student in the elementary school is permitted to carry prescription or over the counter medication.
4. All medications must be in properly labeled bottles from the pharmacy. A second labeled bottle is requested for school trips. If an over the counter medication is to be given, 2 small containers are requested so one can go on field trips with the student.

Screenings

The following is a list of screenings which are performed:

Vision- Students in grades K, 1, 3 and 5 and all new entrants regardless of grade receive vision screening for near vision and distance acuity. In addition, all new entrants regardless of grade are screened for color blindness.