HAUPPAUGE SCHOOLS

Office of the School Nurse

Medical and Emergency Contact Information

Dear Parent/Guardian,

Please note the following regarding health services and your student.

New York State Education Law requires all students to have a physical examination upon entering the school district for the first time, and in grades **Pre-K or K, 1, 3, 5, 7, 9, and 11.** If the cost of the exam is prohibitive, contact the school nurse's office to avail your family of any of the several scheduled examinations with the school physician during the school year.

All medication, even OTC medication such as Tylenol or Ibuprofen need parent written approval and a physician order. Enclosed find a medication authorization form. Students are not allowed to carry any type of medication. Independent students with health conditions warranting timely administration of their medication to prevent negative health outcomes if deemed independent by their private physician, parent and school nurse. Self-carry forms must be completed and filed with the health office and must be a part of the student's health care plan. Parents are advised to keep a back-up medication in school to be used in the event a student forgets. Please review this rule with your child as there are many students who have severe allergies in the school and the result of taking a medication that they are allergic to can be fatal.

If you have any concerns or questions about the health or well being of your student during the school day, please feel free to call your school nurse's office. Additionally, the enclosed forms can be downloaded from the district website.

Thank you.

Hauppauge School District Nurse's

HAUPPAUGE PUBLIC SCHOOLS

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. Must be completed by the parent or guardian:

Authorization for Administration of Prescription and/or Non-Prescription Medication

Student's Name_____Date of Birth_____

I request that my child receive the medication as prescribed below by our licensed healthcare provider.

I will furnish medication in the properly labeled original container from the pharmacy, **including OTC medication ie: Tylenol and Ibuprofen.** I understand that medication will not be accepted if it is not provided in the original labeled container, or if it is not being used according to manufacturer's recommendations. I agree to have my child evaluated by my healthcare provider should the school determine my child is requesting a non-prescription medication excessively. My signature below constitutes permission for the school to contact my healthcare provider regarding this form.

Please indicate if your child is self directed in administration and proper use of this medication:

YES:_____ NO:_____

Signature (Parent or Guardian):_____

Telephone: Home/Cell:_____Date:_____

B. Must be completed by the licensed health care provider:

Authorization for Administration of Medication

I request that my patient receive the following medication:

Name of Medication:_____Dose_____Frequency_____

Route:_____Side Effects_____

Diagnosis:_____

Please indicate if patient is self directed in administration and proper use of this medication:

YES:_____NO:_____IF NOT, EXPLAIN_____

*If the usual morning dose given at home has been forgotten, the nurse may administer it at school after verbal or written notification from the parent.

Drug_____AM Dose_____Time_____

Then administer the second dose as follows:_____hours later or no change_____

SIGNATURE OF HEALTHCARE PROVIDER:_____

NAME OF HEALTHCARE PROVIDER:_____

DATE:_____PHONE:_____FAX:_____

(Please print or stamp)

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 ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ 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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

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.

HAUPPAUGE PUBLIC SCHOOLS

HEALTH HISTORY

(*This form is to be completed by Parent/Guardian*)

NAME:_____SCHOOL:_____GRADE:_____

Has this student ever had any of the following diseases? If YES, when?

	DATE		DATE		DATE
Chicken Pox	_____	**Pneumonia**	_____	**Diabetes**	_____
Diptheria	_____	**Poliomyelitis**	_____	**Epilepsy**	_____
German Measles	_____	**Rheumatic Fever**	_____	**Heart Disease**	_____
Measles	_____	**Scarlet Fever**	_____	**Tuberculosis**	_____
Mumps	_____	**Whooping Cough**	_____	**Contact w/TBC**	_____

Check if the student has had a history of the following and describe:

<u>CONDITION</u> (*Please answer all questions*) <u>DESCRIPTION</u>

Asthma or allergies_____

Ear Conditions_____

Does this student have any hearing difficulty?_____

Frequent colds and/or sore throats_____

Operations_____

Head injuries/concussions_____

Serious injuries_____

Serious illnesses other than above_____

Does this student wear glasses?_____

Does this student take medication? _____ YES _____NO

If Yes, provide name and dosage_____

Is there anything concerning the general health of this student that the school should know in order to provide special care_____

I give consent for this information to be shared with staff who will be working with my child.

Date_____ Parent/Guardian Signature_____

I give the school nurse permission to contact my private physician_____

5/2018 **Doctor's Name**

HAUPPAUGE PUBLIC SCHOOLS

Office of the Director for Pupil Personnel Services

Dear Parent,

In accordance with New York State Public Health Law, a Certificate of Immunization must be kept on file for every student.

To comply with this law, please have your physician complete this form and forward it to your child's school nurse as soon as possible.

Thank you.

STUDENT'S NAME:_____

IMMUNIZATION	**(DATE) #1**	**(DATE)** #2	**(DATE) #3**	**(DATE) #4**	**(DATE) #5**
POLIO (IPV or OPV)					
DTaP/DPT					
Tdap					
MEASLES					
MUMPS					
RUBELLA					
MMR					
HEPATITIS B SERIES					
VARIVAX/VARICELLA					
MENINGOCOCCAL					

_____ _____

PHYSICIAN's SIGNATURE **DATE**

6/2018

HAUPPAUGE PUBLIC SCHOOLS

DENTAL HEALTH INFORMATION

Dear Parent/Guardian:

Good dental health habits, when formed in early childhood, will achieve lifelong benefits. Listed below are recommendations from the American Dental Association.

- Brush your teeth twice a day with fluoride toothpaste. Replace your toothbrush every three or four months, or sooner if the bristles are frayed. A worn toothbrush won't do a good job of cleaning your teeth.
- Clean between teeth daily with floss or an interdental cleaner. This helps remove plaque and food particles from between the teeth and under the gum line.
- Eat a balanced diet and limit between-meal snacks.
- Visit your dentist regularly for professional cleanings and oral exams.

Please have your family dentist complete the Dental Health Certificate and return to your child's school nurse if an examination is completed.

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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.