

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 BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:	
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$	
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>			

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<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/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative <input type="checkbox"/>	Positive <input type="checkbox"/>	Referral <input type="checkbox"/> Yes	Not Done <input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
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"/> Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
<small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When 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	_____
Diphtheria	_____	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:

CONDITION (Please answer all questions)

DESCRIPTION

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 _____



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



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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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): _____

III. 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.