Schroon Lake Central School District

1125 U.S. Rt. 9 PO Box 338 Schroon Lake, N.Y. 12870
Phone (518) 532-7164 Fax (518) 532-0284

DENTAL HEALTH CERTIFICATE

Dear Parent and Dentist;

Effective September 1, 2008 New York State schools must request that parents submit a Dental Health Certificate within 30 days of entrance into the school district and within 30 days of entry into grades 2,3,7, and 10. While the certificate is not mandated for a student to attend school, the certificate, if received, will be filed in the student's Cumulative Health Record. The Dental Health Certificate must be filled out by a licensed dentist.

Sincerely,

Sharon Kelly, RN

Patient's Name: _____ DOB: _____ Grade: _____

Findings and Recommendations: _____

Signature of Dentist: _____ Phone Number: _____

Address: _____

Date: _____

Please fax to: 532-0284

STUDENT HEALTH EXAMINATION FORM (To be completed 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, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: ☐M ☐F

School: Grade: ☐No Grade Exam Date:

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

☐Asthma: ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐Diabetes: ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐Seizures Type: _____ Last Occurrence: _____ ☐Emergency Care Plan Attached

☐Allergies: ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Allergen(s):

☐Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th

☐ 5th - 49th ☐ 95th - 98th

☐ 50th - 84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: ☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities:

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

☐ Full Activity without restrictions including Physical Education and Athletics.

☐ Restrictions/Adaptations. Please base restrictions/modifications on the following Interscholastic Sports Categories.

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

Accommodations / Protective Equipment:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	☐Pacemaker
	☐Brace/Orthotic	☐Medical /Prosthetic Device	☐Sports Safety Goggles
	☐Hearing Aides	☐Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____ _____

_____ _____

_____

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

☐ Required Independent Carry and Use Attestation documentation is attached.

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

rent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse termines my child can take their own medications, trained staff may assist my child to take their own medications. I ll provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff ring for my child

Parent/Guardian Signature:

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: ( )

Provider Address: _____ Fax #: ( )

Return to:

School Nurse: Sharon Kelly, RN School: Schroon Lake Central

Phone #: 518-532-7164 ext: 3495 Fax 518-532-0284 Date:

Tips for Parents from the School Health Office

Many families ask, **"When is my child sick enough to stay home from school?"**

A child who is sick will not be able to perform well in school and is likely to spread the illness to other children and staff. We suggest making a plan for childcare ahead of time so you will not be caught without a comforting place for your child to stay if he/she is ill.

Please DO NOT send your child to school if he/she has:

- Fever in the past 24 hours
- Vomiting in the past 24 hours
- Diarrhea in the past 24 hours
- Chills
- Sore throat
- Strep Throat (must have been taking an antibiotic for at least 24 hours before returning to school)
- Bad cold, with a very runny nose or bad cough, especially if it has kept the child awake at night
- Head lice – until your child has been treated according to the nurse or doctor's instructions
- Red, itchy eye(s) with discharge

If your child becomes ill at school and is too sick to benefit from school or is contagious to other children, you will be called to come and take him/her home. It is essential that we have a phone number where you can be contacted during the day and an emergency number in the event you cannot be reached. Please be sure that arrangements can be made to transport your child home from school and that childcare is available in case of illness. If your daytime or emergency phone number changes during the year, please notify the main office immediately.

Please call the school's Health Office if you have any questions or concerns.

Schroon Lake Central School
532-7164

SCHROON LAKE CENTRAL SCHOOL

MEDICATION POLICY

For students to receive prescription or non-prescription medication in school, the following criteria **MUST** be met:

a. The school nurse must have on file a written order from the family physician which indicates the name of the drug, the frequency and time element for administering the medications, the dosage, and possible side effects. This includes over the counter drugs, i.e., Tums, Tylenol, Ibuprofen, Calamine Lotion, cough drops, etc.

b. The school nurse must have a written request from the parent to administer the medication.

c. The medication needs to be delivered directly to the school by the parent. The medication must be in a container that clearly indicates the name of the medication, date, name of the child and physician, dosage, and frequency.

d. No student will have in his/her possession any prescription or non-prescription medication while at school.

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EMERGENCY MEDICATION PROTOCOL

Goal: To ensure that potentially life-saving medications such as (but not limited to) EpiPens and respiratory inhalers are available and in-date for any student that is prescribed one or more of these medications.

Health Office Protocol:

1: Life-saving medication will be delivered to the Health Office on the **first** day of school by a parent or guardian, along with the physician order sheet. The medication(s) will be picked up at the end of the school year, again by a parent or guardian.

2: Any student that is prescribed a life-saving medication and has written permission from their physician to self-carry and administer are strongly encouraged to have duplicate medication available in the Health Office. This is critical in the event that the student is separated from, or does not have the medication on their person at the time of need.

3. You are strongly encouraged to have any life-saving medication **available and in-date** for your child's use throughout the school year. You will be notified in advance of expiring medications. Thank you for your cooperation.

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF

Prescription and Non-Prescription Medicine in School

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container, and be. delivered to the school by myself or a designated representative of mine. It must be picked up at the end of the school year. A new medication order is needed every school year.
Signature (Parent or Guardian): _____

Telephone: Home _____Work_____Date _____

B. To be completed by physician:

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

Name of Student: _____

Diagnosis:_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

PRESCIBER: When ordering EpiPens, please order the **Dual Pack** in the likely event a second dose is needed before rescue squad arrives.

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Student **may** self-administer: YES or NO Student may **self-carry:** YES or NO

Physician's Signature _____ Date: _____

Address: _____ Phone:_____

_____

- **Any** student requiring an EpiPen **MUST** have it delivered to the Health Office by the first day of school. This is a lifesaving medication and must be on hand in case of an anaphylactic reaction.

Over the counter medications available at SLCS include: Acetaminophen, Ibuprofen, cough drops, Calamine lotion, Benadryl, Turns, and antibiotic ointment. **Please circle any choices**.

Schroon Lake Central School

2015-2016 Health and Dental Examination Requirements

Dear Family;

New York State law requires a health examination for all students **entering the school district for the first time, when entering Pre-K or K, 2nd, 4th, 7th, and 10th grade, and for all sports participation.** The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner. We offer free physicals at school in October and May. They are performed by a provider from Hudson Headwaters Health Network, or you may have it completed by your private physician.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also requested, but not mandatory at this time.

- A copy of the health examination must be provided to the school **within 30 days** from when your child first starts at the school, and when your child starts Pre-K, K , 2nd ,4th ,7th , & 10th grades.
- If your child has an appointment for an exam during this school year that is **after the first 30 days** of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care provider can be printed off.

Please make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number below.

Sincerely,

School Nurse: Sharon Kelly, RN		School: SLCS
Phone #: 532-7164	Fax: 532-0284	Email: sk@slwildcats.org

Schroon Lake Central School District

BMI Reporting Information

Grades K, 2, 4, 7 and 10

Dear family;

As part of the required school health examination, student heights and weights are measured. These numbers are used to determine Body Mass Index (BMI). The BMI is useful in determining if students are in healthy weight ranges. New York State Education Law requires that BMI information be a part of the school health record.

Periodically our school may be selected to report student BMI information to the New York State Department of Health. This information will help officials develop programs that are intended to maintain the health of children. Only summary information will be sent, no names or personal identifiers will be included.

You may choose to have your child's BMI number excluded from the survey by signing and returning the bottom of this form to the Health Office at Schroon Lake Central School.

Please DO NOT include my child's weight status information in the _____ school survey.

(School Year)

Child's Name: _____ Grade: _____

Parent Signature: _____ Date: _____

Sports Participation Medical History (To be completed by Parent/Guardian)

Name:_____ Grade:___ Age:_____ Date:_____

Dear Parents: We want to assure, as well as possible, your child's safety for sport's participation. Please complete the following medical history about your child:

1: Has he/she had any serious illness or injury since their last regular or sport physical exam? __No __Yes

2: Have any family members under age 50 had a heart attack, heart problems, or died suddenly of causes other than an accident? __No __Yes

3: Have he/she ever been told they have a heart murmur, high blood pressure, extra heart beats, or a heart abnormality? __No __Yes

4: Is he/she missing any organs (eye, kidney, spleen, testicle, etc.)? __No __Yes

5: Has he/she ever had chest pain, fainting, or dizziness with exercise? __No __Yes

6: Has he/she ever "passed out", been "knocked out"(concussion), had trouble with heat exhaustion, or had seizures(convulsions)? __No __Yes

7: Is he/she on any regular medications, supplements, or performance enhancing medicines? __No __Yes

8: Does he/she have to stop while running twice around a standard track (400 meters / *a* mile)? __No __Yes

9: Other than a minor flu or other common medical illness, has he/she ever had an illness, injury or condition that:

- A: Required hospitalization, emergency room treatment, or x-ray> __No __Yes
- B: Required an operation? __No __Yes
- C: Lasted longer than a week? __No __Yes
- D: Caused you to miss a game or practice? __No __yes
- E: Is related to allergies (asthma, hay fever, hives, medicine)? __No __Yes

10: Does he/she wear glasses, contacts, have false teeth or use other medical or protective appliances? __No __Yes

11: Are you concerned about his/her weight? (or weight loss for sport?) __No __Yes

12: (Female only) Are her periods regular? Does she have menstrual problems? __No __Yes

Further Information on "Yes" Answers:

Your signature gives permission to allow our school physician to perform the physical exam, free of charge. (Signature)_____

Sports Exam (to be completed by MD/CNP/PA)

Name:_____ Date:_____

Hgt: ___ Wgt: __ BMI:__ Pulse: Resting: ___ Exercise:___ Recovery: ___ BP: ___/___

Vision screen done ___ Hearing screen done __

	N	Dental: N		N	Stage:
Skin			Abdomen		
Eyes			Liver		
Mouth			Spleen		
Nose			Genit.		
Neck			Tanner		
	N			N	
Chest			Ortho.		Scoliosis: N
Heart			Spine		
Pulses			Upper Ex		
Lungs			Lower Ex		

Summary

1. Full Participation ___
2 Limited Participation ___ Type
3 Needs Further Evaluation ___ Type
4 No Participation ___

_____

Signature: MD/CNP/PA

Classification of Sports

Strenuous			Moderately Strenuous	Non-strenuous
Contact	**Limited Contact**	**Non-contact**		
Football Ice Hockey Lacrosse(boys) Rugby Wrestling	Basketball Field Hockey Lacrosse(girls) Soccer Volleyball Gymnastics Skiing	Crew Cross country Fencing Swimming Tennis Track+Field Water polo	Badminton Baseball Golf Table Tennis Curling	Archery Bowling Riflery

School Nurse review/concerns: