



ST BRIGID/OUR LADY OF HOPE REGIONAL SCHOOL

101 Maple Avenue, Westbury, NY 11590 • (516) 333-0580 • www.stbolh.org

HEALTH DOCUMENT REQUIREMENTS

The New York State Education Law requires all students to have a medical examination upon original entry into school and routinely at grades Pre-K, Kindergarten, 1,3,5 and 7.

- **New students** must have all medical forms completed with results and forms signed by a New York State physician submitted before the first day of school. Medical forms must be dated after September 1, 2021.
- **All Students entering Toddler, Toddler Plus, Nursery, Pre-K, Kindergarten and Grades 1, 3, 5, and 7** must have completed and signed medical forms before classes begin in September or your child will not be permitted to attend class on the first day of school.

Grade 7 must have proof of meningitis and Tdap vaccine.

Grade 6 must have proof of Tdap vaccine.

MEDICATION:

Should your child need to take medication in school, the attached Medication Form must be filled out and signed by your child's doctor. Medication will be kept in the Health Office, with the exception of middle school students who have a medical note for self carry.

ATTACHMENTS:

1. School Health Form
2. Medication Form

ST BRIGID/OUR LADY OF HOPE REGIONAL SCHOOL

101 Maple Avenue, Westbury, NY 11590 • (516) 333-0580 • www.stbolh.org



MEDICATION IN SCHOOL

According to the New York State Law, the only way medication can be given during school hours is if the school nurse receives a doctor's note stating the name of the medication, the dosage, the time to be given, and a note from the parent giving the school nurse permission to give the medication. This signed form is to be used for all over-the-counter and prescription medication.

Please do not have medication in school for a child to take on his/her own. We have many children who are allergic to various drugs. If these should unknowingly fall into their hands, the results could be fatal.

MEDICATION FORM

To the PHYSICIAN: (please complete)

Child's Name _____

Medication _____

Dosage _____

Time to be given _____

Physician's Signature _____

To the PARENT (please complete)

I give my permission to the School Nurse to administer the medication as prescribed above by my doctor for my child.

Parent Signature _____

If you have any questions, please feel free to contact the School Nurse. Thank You.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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 <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<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
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	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: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$				

System Review and Abnormal Findings Listed Below

<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

Assessment/Abnormalities Noted/Recommendations: Diagnoses/Problems (list) ICD-10 Code*

Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:				DOB:	
SCREENINGS					
Vision (w/correction if prescribed)		Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
Notes					
Hearing 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"/> No	<input type="checkbox"/>
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK					
<input type="checkbox"/> Student may participate in all activities without restrictions. <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 Age of First Menses (if applicable) : _____					
<input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached					
IMMUNIZATIONS					
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS			
HEALTH CARE PROVIDER					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form To Your Child's School When Completed.					