Waterville Central Schools WATERVILLE NY 13480

HEALTH OFFICE
KATHLEEN EISENHUT, RN
keisenhut@watervilleschools.org
Phone: 315.841.3821 Fax: 315.841.3813

Dear Parent/Guardian:

New York State Education Law and Regulations of the Commissioner of Education requires physical examination for children:

- In 7th and 10th grade
- Play a sport
- Request working papers
- New entrant

Your child falls into one of the above categories. For your convenience; we are enclosing a physical form, parental permission form, and dental form. Please return these documents to the Health Office at Waterville Jr. Sr. High School.

Please complete the form below and return by _____.
If I have not received a response by this date, a physical will be scheduled and given by our school Nurse Practitioner Julie Shankman.

1._____ A current physical has been done. A copy is attached.

2._____ My child will have a physical done by their primary doctor **on**_____.

3._____ I authorize the School Nurse Practitioner to do a physical on my child.

_____
Student Name

_____ _____
Parent/Guardian Signature Date

If you have any questions, please feel free to call me at 841-3821.

Thank you,
Kathleen Eisenhut RN
Kathleen Eisenhut RN

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: ☐ M ☐ F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ _____ - _____

Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

OPTIONAL INFORMATION, If known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

Waterville Central Schools WATERVILLE NY 13480

Health Office
Kathleen Eisenhut RN
keisenhut@watervilleschools.org

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider listed below to release my child's _____ medical records to the district's school nurse:

Name: _____ Phone: _____ Fax: _____

The healthcare provider may disclose the following protected health information:

- Immunizations
- Health Appraisals/physical
- Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT,OT,ST needs
- Other

The Protected Health Information may be used, disclosed or received for the following purpose(s):

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery and/or therapy prescriptions for PT,OT,ST
- At patient's request with no specified purpose
- Other_____

Please select one:

_____ This authorization is valid for the entire academic school year 20__-20___

_____ This authorization shall expire on ___/___/___ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the school nurse. I understand that the revocation of this authorization is not effective if the Healthcare provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date Signature of Patient (Over 18), Parent, or Guardian Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Waterville Central Schools WATERVILLE NY 13480

JR. SR. HIGH SCHOOL HEALTH OFFICE
KATHLEEN EISENHUT, RN
keisenhut@watervilleschools.org
Phone: 315.841.3821 Fax: 315-841-3813

Medication Administation

School Policies regarding administrations of medications are consistent with procedures **established by the State Education Department/State of New York.**

For students to receive medication (prescriptions **or** non-prescriptions, including cough drops , Tylenol, Advil , and other "over the counter" drugs) during the school day, the following procedures MUST be followed and **renewed** each year.

- The **parent** or legal guardian must submit a **written** request to the school authorities **together** with a **written** request from **their own physician** indicating the name, frequency and dosage of the medication, to be given by the nurse during school hours.
  Forms are available in the Nurse's office or on Nurse's website.
- The medication must be brought to the school by a responsible adult in the **original** container labeled with the name of the drug and the dosage.
- Medication should **NOT** be brought to and from school. Please supply only what is needed during the hours of school and keep the rest at home.
- Students may **NOT** carry the medication on themselves. With the **exception** of inhaler use for asthma. Your family doctor and parent must indicate in writing that your child may carry his/her inhaler during school hours/sports. **Special** forms for self administration of inhalers are available in the Nurses office.
- **Epi-pens** may be carried if parent/physician deems it necessary for allergic reactions. Special forms must be completed by the parent and physican. These forms can be obtained at the Health Office and
- Unless all procedures are followed medication **CANNOT** be administered at school.

If the above procedures are not followed discipline procedures as outlined in the student handbook will be followed.

First Offense – A warning and parental notification.

Second Offense – Parental conference with the building principal.

Disciplinary actions (i.e. detentions, suspensions) may be taken.

If you have any questions or concerns, please contact theHealth Office.

Waterville Central School
Nurse's Office
Fax-315-841-3813

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the Licensed Health Care Prescriber

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

Name of Student _____ DOB _____

Diagnosis _____

Name of Medication _____

Prescribed dosage and route of administration _____

Frequency and time to be taken during school hours _____

Duration of treatment _____

For PRN medications – list conditions under which medication should be administered

_____

Name of Licensed Prescriber & Title (please print) _____

Prescriber's signature _____ Date _____

Issuing Physicians Office _____ Phone _____

//

B. To be completed by parent or guardian:

I request that my child _____ grade _____, receive the medication as prescribed above by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

I also hereby request that my child's teacher or other designated faculty member administer the medication on such school-sponsored activities such as field trips, athletic events, etc. during the _____ school year.

The above medication is to be administered during the current school year or until terminated by written notice.

Signature of Parent/Guardian: _____

Address _____

Phone (home) _____ work _____

Date: _____

Waterville Central School
Waterville, New York

AUTHORIZATION FOR SELF/ADMINISTRATION OF MEDICATION
*****INHALER/EPI-PEN ORDERS ONLY*****

A. To be completed by the Licensed Health Care Prescriber:

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

Name of Student _____ DOB _____

Diagnosis _____

Name of Medication _____

Prescribed dosage and route of administration _____

Frequency and time to be taken during school hours _____

Duration of treatment _____

For PRN medications – list conditions under which medication should be administered

_____

Name of Licensed Prescriber & Title (please print) _____

Prescriber's signature _____ Date _____

Issuing Physicians Office _____ Phone _____

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B. To be completed by parent or guardian:

I request that my child _____ grade _____, receive the medication as prescribed above by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

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Signature of Parent/Guardian: _____

Address _____

Phone (home) _____ work _____ Date: _____

//

*C MUST BE COMPLETED IF STUDENT IS TO *CARRY* EMERGENCY MED*

This pertains to the administering of emergency medications ONLY, (INHALER/EPI-PEN)

All other medications must be kept in the Health Office

C. We (physician's signature) _____

And (parent/guardian) _____

Request that (child's name) _____ be permitted to carry the medication on his/her person or to keep same I his/her locker, PE locker, as we consider him/her responsible and **self-directed**. He/she has been instructed in and understands the purpose and appropriate method and frequency of use. As the parent/guardian, I accept the responsibility regarding monitoring of my child on an ongoing/daily basis to insure that the child is carrying and taking the medication as ordered.

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 visit to a dentist? ☐ 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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam 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 name and address (please print or stamp)

Dentist'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.

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Prescriber's signature _____ Date _____

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The above medication is to be administered during the current school year or until terminated by written notice.

Signature of Parent/Guardian: _____

Address _____

Phone (home) _____ work _____

Date: _____

Waterville Central School
Waterville, New York

AUTHORIZATION FOR SELF/ADMINISTRATION OF MEDICATION
*****INHALER/EPI-PEN ORDERS ONLY*****

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Diagnosis _____

Name of Medication _____

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SAMPLE

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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 visit to a dentist? ☐ 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.

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Dentist's name and address (please print or stamp)

Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

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☐ 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].

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