Our Lady of Wisdom School

A Letter from the School Health Office

I'd like to take this opportunity to welcome you and your children to the new school year at the Our Lady of Wisdom Regional School. For your convenience, I'd like to review the following information:

ILLNESS

For the health and safety of all of the children in school, we ask that you keep your children home from school when they are ill. A child should be free from fever (over 100 degrees) for 24 hours before returning to school. Please notify the Health Office (631 473-1896 or email; ahampson@portjeffschools.org) when your child is absent from school. Your child will be considered illegally absent from school until we receive an excuse from you.

PHYSICALS

Physicals are required by New York State Law for children in Pre K., Kindergarten, grades 1, 3,5 & 7 and for all children who are new to the school. The required forms are included in this packet and should be returned to the Health Office by the second week of September. Acceptable health certificates may be dated **anytime within the12 months prior to the start of the new School Year**. If you need another form, you can download the form from our website or obtain it from the health office. Any child who was not seen by his/her health care provider by then will be scheduled to see the school physician. Dental exams are recommended for the same grades. These forms can also be downloaded from the website or in the health office.

MEDICATION

New York State law mandates that **no medication, not even over the counter medication such as Tylenol or Advil, may be administered in school without physician and parental authorization.** Please print a medication authorization form and return it to the health office with the medication which should be in pharmacy packaging and clearly labeled with the students name and delivered to the health office by an adult.

FORMS

Please return all health related forms to the health office in a timely fashion. Ie: emergency contact forms, medication forms, action plans etc.

***Please note all forms are valid for the current school year only.**

FOOD ALLERGIES

As there is an increasing prevalence of food allergies among children and because there is no cure, avoidance of these allergens is the only way to prevent reactions. Our goal at Our Lady of Wisdom is to reduce the likelihood of severe potentially life threatening allergic reactions. We are achieving this by having the staff trained how to recognize an allergic reaction and to use an EPIPEN this will ensure a rapid response in case of a severe or potentially life threatening allergic reaction.

The level of sensitivity and the types and severity of reactions vary considerably among individuals with food allergies. Therefore our schools approach to preventing and treating food allergies must be tailored to those individuals needs. This is why there may be instances where a classroom is designated as **"Nut Free."** In this case you will be informed by the class teacher and requested **NOT** to include foods in your child's snack that contain any kind of nuts. Please note grades 6-8 do not have snack. Our school policy also states that only select celebrations will include food (a signed permission slip will be required to participate).

All field trips are "Nut Free".

Parents with children who have food allergies are asked to file a current and updated **Food Allergy Action Plan**, including a photograph, with the health office. Please send this in promptly.

ACTION PLANS

If your child has been diagnosed with severe allergies, asthma, or other specific medical conditions, you may receive or can print from our website an **Action Plan** to fill out and return to the health office. These Action Plans provide instruction to the school nurse and to teachers in direct supervision of your child that will assist us in giving your child the care he/she requires during the school day.

Please check the school's website for additional health information, for downloadable forms and throughout the school year for health updates. I look forward to providing a safe and healthy learning environment for your children.

Arin Hampson, RN

631 473-1896

Our Lady of Wisdom Regional School

Emergency Contact Form

Name:		School Year/Grade	2019-2020 /
Date of Birth:	Sex:	District	

Address:	
Home phone:	
Mothers Name:	cell phone:
Mothers work:	work phone:
Fathers Name:	cell phone:
Fathers work:	work phone:

HEALTH ISSUES AND CONDITIONS	
Acute illness, injuries or operations/hospitalizations this past year (list dates):	
Health concerns or physical conditions that may need special attention in school:	
Asthma: Yes / No Explain: Student carries his/her own inhaler: Yes / No	
Allergies: Yes / No Explain:	
Activity restrictions:	
Glasses/contacts:	Hearing impairment:

MEDICATIONS
Medications given at home:
Medications to be given at school:

PHYSICIAN INFORMATION	
Primary physician:	Phone:
Dentist:	Phone:

EMERGENCY CONTACTS		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Parent/Guardian Signature: _____ **Date:** _____

Our Lady of Wisdom School is requesting the above information in connection with your child's enrollment in the School and State law which requires that the School keep health records of each school-age child. The data you supply will be used by the School District for the purposes of contacting you or those you have authorized in case of emergency and to address health and safety issues pertaining to your child.

The data you provide is classified by the School as private educational data. This data may be shared with health service staff, administration and other staff members who have a legitimate educational interest in the information.

A Letter from the School Health Office

Dear Parents/Guardians,

Date: 2019-2020 school year

As of July 1, 2018 New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th , and 11th grade**.

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner and on the approved NYSED Student Health Examination Form for School which is enclosed in this packet.

We understand that your medical provider's office may not yet be aware of the change, so if you have already had a physical examination completed for the 2018-19 school year on a different form, the school may accept the physical on that form. **In 2019-2020 ONLY the approved form will be accepted.**

We understand that your medical provider's office may not yet be aware of the change, so if you have already had a physical examination completed for the 2018-19 school year on a different form, the school may accept the physical on that form.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- 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 K , 1st , 3rd, 5th, 7th, 9th, & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- 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 providers is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you 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.

We appreciate your time in collaborating with us to provide your child/patient and our student with the required documentation as required by law.

Arin Hampson RN

631 473-1896

ahampson@portjeffschools.org

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.

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

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 from the pharmacy*.

PLEASE CHECK ONE:

- ☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips to my **self directed child**
- ☐ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

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:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____Date:_____