

**EDGEMONT JUNIOR-SENIOR HIGH SCHOOL**  
200 WHITE OAK LANE  
SCARSDALE, NEW YORK 10583

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**HEALTH OFFICE**

(914)725-1500, ext.1250 or 1576

Fax (914)725-4032

[mbajorin@edgemont.org](mailto:mbajorin@edgemont.org)

[kburbage@edgemont.org](mailto:kburbage@edgemont.org)



Dear Parents/Guardians:

In accordance with the New York State Education Law, rising 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> graders are required to have a current physical exam for the beginning of the school year. Please remember that if your child participates in interscholastic sports their physical expires one year from the date of their last examination.

In this packet you will find:

1. **Annual Health and Sports Exam Form** (*required for both sports participation, and state health exam mandate*): In accordance with New York State Education Law, your physician must complete, sign and date the attached form. **\*\*No other forms or attachments will be accepted.**
2. **Medication Authorization Form**: To comply with New York State Education Law, *this form must be completed by both a parent and physician prior to administering any medication to your child during school hours.* This is required for any prescription medication, or non-prescription (OTC). All medications must be delivered by a parent to an authorized school official, in the original container with the child's name.  
  
**\*\*For EpiPen, inhalers or diabetic meds., please contact the nurses directly.**
3. **Dental Form** (*required*): Please complete at most recent appointment within the year.

**Forms are available on the EHS website in the School Info tab and Quicklinks**

**For sports registration and information** please call the Athletic Directors office at (914) 725-1500 ext. 1592/1570. You can also get information from the Athletic page on the EHS website.

**To report absences,** call the Attendance Clerk at 725-1543 prior to 9 a.m.

Please feel free to contact us if you have any questions or concerns.

Sincerely,

A handwritten signature in blue ink that reads "Mireille Bajorin R.N." The signature is written in a cursive style.

Mireille Bajorin, R.N.  
EHS School Nurse

A handwritten signature in blue ink that reads "Kathy Burbage R.N." The signature is written in a cursive style.

Kathy Burbage, R.N.  
EHS School Nurse

**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**

<b>Allergies</b> <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
<b>Asthma</b> <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
<b>Seizures</b> <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:
<b>Diabetes</b> <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):**  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  No  Yes  Not Done **Hypertension:**  No  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns</b> (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"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g}/\text{dL}$				
<input type="checkbox"/> <b>System Review and Abnormal Findings Listed Below</b>				
<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
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			<input type="checkbox"/> Diagnoses/Problems (list) <span style="float:right">ICD-10 Code*</span>	
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision</b> (w/correction if prescribed)		<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
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					
<b>Hearing</b> 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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
Notes					
<b>Scoliosis</b> Screen Boys in grade 9, and Girls in grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process</b> <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <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"/> <b>Other Accommodations*:</b> (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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS			
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					

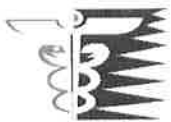
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## HEALTH OFFICE

(914)725-1500  
ext. 1576 (M. Bajorin)  
ext. 1250 (K. Burbage)  
Fax (914)725-4032



Dear Parents/Guardians:

**In order to comply with New York State Education Law, the following steps must be taken if your child requires either prescription or over-the-counter medication during the school day:**

1. The school nurse must have on file a written and signed request from **both** the physician and the parent. The attached form has been provided for your convenience.
2. All medication must be **delivered** to the school nurse **by the parent**. (Advil, Tylenol and Benadryl tablets are the only medications stocked in school. Any other medications, including liquid and chewable, must be provided by you.)
3. The medication must be in the **original container**, as it is received from the pharmacist or over-the-counter: **with the child's name, the name of the medication, and a description of the dosage.** Please get a second labeled prescription bottle from your pharmacist and deliver only what will be required during school hours.
4. All medication must be kept in the school nurse's office.
5. Inhalers and EpiPens are the only medications that students may carry, and only if the school nurse has on file a physician's order *and* a self-administration waiver. This form is available upon request.
6. All medications must be picked up by a parent or parent representative. We are not able to allow your students to carry their own medications.

*Please do not hesitate to contact Mrs. Bajorin, R.N. (Grades 10<sup>th</sup>-12<sup>th</sup>) or Mrs. Burbage, R.N. (Grades 7<sup>th</sup>-9<sup>th</sup>), our school nurses, for further information and forms.*

Sincerely,

Kyle Hosier  
Principal

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**MEDICATION AUTHORIZATION FORM**

Individualized Orders for: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

Allergies: \_\_\_\_\_

**1. Standard Over-the-Counter/PRN Medications:** The following medications are the *only* ones available in health office. For any other medications, see below. These medications will be administered at the discretion of the R.N. per label instruction by age and weight, or as specified by M.D., ***only if signed approval is indicated by BOTH the student's physician AND parent.***

Drug Name	Route	<u>DOSAGE</u>	Schedule & Indications	Comments
Tylenol tablets (acetaminophen)	po	325 mg.	Q4 hr. as needed for pain or fever	
		650 mg.		
Advil tablets (ibuprofen)	po	200 mg.	Q6 hr. as needed for pain or fever	
		400 mg.		
Benadryl capsules (diphenhydramine hydrochloride)	po	25 mg.	Q4 hr. as needed for allergic reaction, hives	
		50 mg.		
TUMS	po	500mg	PRN as needed for indigestion/upset stomach	
		1 Gm.		

**2. PRESCRIPTION and any other Over-the-Counter Medications:** PHYSICIAN, please complete with patient's current regimen for both scheduled and PRN medications.

**\*All prescription medications must be provided directly to the nurse by a responsible adult in the original container with your student's name on it.**

Drug Name	Route	<u>DOSAGE</u>	Schedule & Indications	Comments

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**\*\* I authorize the school RN (and on trips, the EMT/ authorized chaperone) to dispense the medication prescribed by the above physician:**

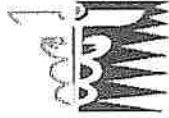
\*\*Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**DENTAL FORM**

**Name of Pupil:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

Dear Parents/Guardians:

NYS Education Law (Section 136.3) requires medical and dental examinations of all students entering grades **seven** , **nine** and **eleven** as well as **new students at any grade level**. This is in order to maintain and improve the level of good health.

Please have this form filled out by your family dentist at the time of your child's dental examination. Treatment and correction of any defects found by the dentist, as soon as possible, are the most desirable procedures for any child.

- Patient has been examined and requires no treatment at this time
- Patient is under dental treatment at this time
- Patient has completed all dental treatment

**Remarks:** \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dentist