

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

HEALTH OFFICE

(914)725-1500, ext.1576

Fax (914)725-4032

kburbage@edgemont.org

jkimball@edgemont.org



Dear Parents/Guardians:

Please use this packet of forms for your rising 8th, 10th and 12th grade student. If your child participates in interscholastic sports, their physical exam expires **one year** from the date of their last examination. You can view the most current exam date we have on file for your child by logging into your Family ID registration portal.

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 this 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

Forms are available on the EHS website in the school info tab and Quicklinks

For sports registration and information please call the Athletic Director's 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 questions or concerns.

Sincerely,

Kathy Burbage R.N.

Kathy Burbage R.N.

Joy Kimball R.N.

Joy Kimball R.N.

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	Type:	
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other :	
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No	Type:	Date of last seizure:
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
Diabetes <input type="checkbox"/> No	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2	
<input type="checkbox"/> Yes, indicate type	<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 <input type="checkbox"/> Negative <input type="checkbox"/>	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 $\mu\text{g/dL}$				
<input type="checkbox"/> 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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
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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/

Yes No

Near Vision Acuity

20/

20/

Color Perception Screening Pass Fail

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** Pass Fail **Left** Pass Fail **Referral** Yes No

Notes

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7

Negative

Positive

Referral

Not Done

Yes No

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

- Student may participate in all activities without restrictions.
- Student is restricted from participation in:
 - Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
 - Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
 - Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
 - Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY 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: I II III IV V Age of First Menses (if applicable) : _____

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

Order Form for Medication(s) Needed at School Attached

IMMUNIZATIONS

Record Attached Reported in NYSIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:

Fax:

Please Return This Form To Your Child's School When Completed.

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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. The medication must be **delivered** to the school nurse **by the parent. or parent representative.** (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.

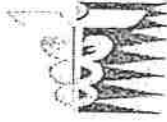
Please do not hesitate to contact Ms. Burbage R.N. or Ms. Kimball R.N. our school nurses, for further information and forms.

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: _____