EDGEMONT JUNIOR-SENIOR HIGH SCHOOL

200 WHITE OAK LANE
SCARSDALE, NEW YORK 10583

HEALTH OFFICE
(914)725-1500, ext.1576
Fax (914)725-4032
mbajorin@edgemont.org

Dear Parents/Guardians:

In accordance with the New York State Education Law, **rising 7th, 9th and 11th graders** are required to have a current physical exam for the beginning of the school year. This includes any exam completed the previous October 2018 or after. Please remember that if your child participates in interscholastic sports their physical expires **1 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 this form.

2. **Medication Authorization Form**: In order to comply with New York State Education Law, if it is necessary for your child to take either prescription or any non-prescription (OTC) medications during school hours, this form must be completed by both a parent and physician prior to administration. All medications must be delivered by a parent to an authorized school official, in the original container with the child's name. NO MEDICATIONS WILL BE DISPENSED WITHOUT THIS.

3. **Dental Form** (***required***): Please complete at most recent appointment within the year.

MOST FORMS ARE NOW AVAILABLE ON THE EHS WEBSITE

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 me if you have any questions or concerns.
Sincerely,

Mireille Bajorin, RN

Mireille Bajorin, R.N.
EHS School Nurse

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.

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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 or on school trips:

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 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.

3. 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.)

4. All medication must be kept in the school nurse's office.

5. Inhalers, EpiPens and diabetic supplies are the only medications that students may carry, but 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., our school nurse, for further information and forms.

Sincerely,

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

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	*DOSAGE*	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 (Section136.3) 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