HARRISON CENTRAL SCHOOL DISTRICT
PROOF OF IMMUNIZATION

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).

IMMUNIZATION HISTORY

DTaP/DT/Td					
Tdap					
Polio – IPV					
Live Measles Vaccine	#1	#2	Disease		
Live Mumps Vaccine	#1	#2	Disease		
Live Rubella Vaccine	#1	#2	Disease		
Varicella	#1	#2			
Hepatitis B Vaccine	#1	#2	#3		
Hepatitis A	#1	#2	#3		
MenACWY (Menactra/Menveo)	#1	#2			

TUBERCULIN SKIN TEST

*** If the student has had a medically documented, positive TST in the past, the test need not be repeated. Go to Section B below.

A. Tuberculin Skin Test (Mantoux/Intermediate PPD) – <u>WITHIN 12 MONTHS OF ENTRY</u>

Test must be read by a <u>health care provider</u> 48-72 hours after administration. If there is no induration, indicate "0" under results. <u>Tine or Mono-Vac tests are not accepted</u>.

Date test administered: ____/____/____ Date test read: ____/____/____ Result: ____mm induration

Test interpretation (refer to table below): ☐ Negative ☐ Positive

Risk Factor	Positive Result
Close contact with case of TB/is immunocompromised	5 mm or more
Born in country with a high rate of tuberculosis	10 mm or more
Traveled or lived for a month or more in a country with a high rate of tuberculosis	10 mm or more
No risk factors (PPD should not be performed)	15 mm or more (if PPD done)

B. If Tuberculin Skin Test is <u>Positive</u>, now or previously, the following are required:

1. Date of Positive PPD: ____/____/____
2. Chest X-ray: (please attach copy of report) ____/____/____ ☐ Normal ☐ Abnormal
   If Abnormal, describe: _____
3. Clinical Evaluation: ☐ Normal ☐ Abnormal
   If Abnormal, describe: _____
4. Treatment: ☐ No (please explain): _____
   ☐ Yes (Drug, Dose, Frequency, Dates): _____

C. Tuberculin Skin Test screening not indicated (Student has none of the above risk factors): _____
(Physician's Signature Required)

Physician's Signature: _____ Phone: _____

(Physician's Stamp below)

Physician's Name/Address: _____ Fax: _____

This health appraisal complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school physician.

HARRISON CENTRAL SCHOOL DISTRICT

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name: DOB: Gender: ☐ M ☐ F

School: Grade: ☐NA Exam Date:

HEALTH HISTORY

Specify Current Diseases

☐Asthma (☐Intermittent or ☐Persistent)
Quick relief inhaler: ☐Yes ☐No
Asthma Action Plan: ☐Yes ☐No
☐Type 1 Diabetes ☐Type 2 Diabetes
☐Hyperlipidemia ☐Hypertension
☐Other:

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:

☐ Allergies - See page 2 for details.

Significant Medical/Surgical Information:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive
Degree of deviation: _____
Angle of trunk rotation via scoliometer: _____

Body Mass Index:
Weight Status Category (BMI Percentile):
☐ <5th ☐ 85th- 94th
☐ 5th- 49th ☐ 95th- 98th
☐ 50th-84th ☐ 99th & higher

Vision	**Right**	**Left**	***Referral***
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐Pass	☐Fail	

Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: ☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ See attached
Specify any abnormalities:

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

☐ Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)
☐ Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,
☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,
☐ Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking
☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:
☐ Medical/prosthetic device:
☐ Recommendations/restrictions:

Name: DOB:

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

***Self Directed**: I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry**: I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

To be completed by Parent/Guardian if medication is prescribed

☐ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/package with my child's name on it.

Parent/Guardian Signature: Date: Phone: ( )

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature: Date: Phone: ( )

ALLERGIES

☐ **None** ☐ **Non Life-Threatening** ☐ **Life-Threatening**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: ☐History of anaphylaxis; last occurrence:

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

IMMUNIZATIONS

☐ Immunization record attached
☐ Immunizations reported on NYSIIS
☐ No immunizations received today

☐ Immunizations received today:

☐ Will return on: to receive:

Provider / Parental Authorization

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: Date:

Provider Name: (please print) Phone #:

Provider Address: Fax #:

Parent/Guardian Signature: _____ Date:

Medical Provider Email:

Return to:

School Nurse: School:

Phone #: ( ) Fax: ( ) Date: