ST. LUKE'S SCHOOL ♦ 487 HUDSON STREET ♦ NY, NY 10014 ♦ PHONE (212) 924-5960 ♦ FAX (212) 924 1352

ANNUAL HEALTH FORM FOR MEDICAL PROVIDER

**** Medical Provider may use their own form, but MUST ALSO SIGN AND ATTACH THIS FORM**

Last Name _____ First Name _____ DOB_____ **DATE OF EXAM** _____

Height _____ **Weight** _____ **lbs** **BMI**_____ **%** **Pulse** _____ **Resp** _____ **BP** ____ /_____

********** IMMUNIZATION RECORD: PLEASE ATTACH OFFICIAL VACCINATION RECORD **********

SCREENINGS

Date	Screening	Result/Value
	VISION	R: L:
	HEARING	R: L:
	Blood Lead	µg/dL
	PPD Mantoux	mm
	Chest X-Ray	☐ NL ☐ Abn F/U:

Hx Chickenpox Disease: YES NO

Additional Screenings/Health Information :

ASTHMA

History of asthma: ☐ NO ☐ YES **(please complete the Asthma/Allergy Plan of Care Form)**

ALLERGY

Any allergies: ☐ NO ☐ YES **(please complete the Asthma/Allergy Plan of Care Form)**

PARTICIPATION

The child is free from contagions and is physically qualified for all physical education, sports, playground, and school activities: ☐ NO ☐ YES

If no, please explain below:

MEDICATIONS

Does the child require any medication to be given in school? ☐ NO ☐ YES

If yes, please list medication and instructions below:

OTC MEDICATION AUTHORIZATION/CONSENT

School Nurse may administer medications below with provider and parent consent (dose/interval based on weight per package instructions). On school trips, student with prescribed medications may be directed with supervision/support of trained staff. Consent covers the school term or 12 months from date.

Signature of medical provider below indicates authorization for these OTC medications unless otherwise specified.

Ibuprofen	Antibiotic Ointment	Benadryl PO/topical	Saline eye drops
Acetaminophen	Cortisone 1% cream	Cetirizine (Zyrtec)	
		Loratidine (Claritin)	

Physician Name:_____ **OFFICE STAMP (if available):**

Phone: _____ Fax:_____

Signature:_____ Date:_____

ASTHMA/ALLERGY PLAN OF CARE

****To be filled out by Medical Provider**

Student Name_____ **Date of Birth**_____**Age**_____**Weight**_____**lbs**

****The following constitutes medical orders for medication administration by the School Nurse (RN)**

ALLERGY PLAN

Allergens: ☐ Peanut ☐ Tree Nuts ☐ Soy ☐ Dairy ☐ Egg ☐ Shellfish ☐ Wheat ☐ Other_____
Indicate severity of each allergen: _____

_____

CONFIRMED by testing? ☐ NO ☐ YES Age_____
Any history of anaphylaxis? ☐ NO ☐ YES Age____

TREATMENT

Epinephrine IM: ☐ 0.3mg Adult ☐ 0.15mg Junior Brand_____
☐ Immediately after: ☐ *Known* ingestion: ☐ even if *NO* symptoms ☐ only if symptoms *ARE* present
☐ *Suspected* ingestion
☐ Inhalation ☐ Touch

Antihistamine:
☐ Benadryl_____mg PO ☐ Cetirizine HCL_____mg PO ☐ None

**Antihistamine will not be delegated to staff for administration. School staff will be trained for recognition of severe allergic reactions and will only administer epinephrine for anaphylaxis when RN is unavailable and on class trips. (NYC DOE Reg.A-715)
**Initiation of 911 REQUIRED in the event of administration of Epinephrine for anaphylaxis.

ASTHMA PLAN

Classification: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ Other:_____

Triggers: ☐ Dust ☐ URI ☐ Mold/Mildew ☐ Animal:_____

☐ Exercise: pre-medicate prior to exercise with: _____

Medication for School Administration (A spacer is required for all inhalers)
_____Dose/Route_____Interval_____ ☐ PRN

_____Dose/Route_____Interval_____ ☐ PRN

Student may carry and self-administer medication: ☐ NO ☐ YES

Medications taken at home on regular basis for Asthma:_____

*****A spacer is recommended for each MDI provided for school administration.***
***Student will be directed with support/supervision of trained staff on class trips when RN is not present.*

Medical Provider's Name: _____ **Signature:** _____ **Date:** _____

OFFICE STAMP (if available):