The Gow School

Dear Gow Families, July 2021

The Health Office is in full swing as our summer program is underway. I would like to introduce myself, Kathy Faltyn, RN, Director of Health Services, and my colleague, Halila Reisdorf, RN. We are the full-time nurses that will be tending to your child's care.

Due to New York State health regulations each year, ***your child must have a Complete Physical Exam and a current immunization record must be sent, before coming to campus for the start of the year.*** The forms are also available electronically on the website at www.gow.org.

All insurance claims that do not fall under the policy guideline of your plan will be billed directly to your home address by the healthcare provider. International Students that have coverage with American Insurance Company are not affected by this change.

At certain times during the year, we are required to perform diagnostic tests for diagnosis and treatment of illnesses and adherence to the policies of The Gow School. The fee for drug testing is $25.00 USD.

Under New York State Law, any prescribed or over the counter medicine that your child is taking must be given to the health office upon your arrival. This includes vitamins, Motrin, Tylenol and antacids. The goal of the school nurses is to keep our students safe and healthy, please help us meet this goal by turning in all medications to the health office.

The Health Office is an open, compassionate, fair, and friendly place. We are here to provide confidential, caring treatment. Please contact Nurse Kathy anytime during the school year with your concerns. We are available from 8:30 am - 9:30 pm Monday-Friday, 7:00 am – 5:30 pm on Saturday and 9:00 am – 9:00 pm on Sunday. You can contact us at 716.687.2084. You can email us at kfaltyn@gow.org, and the fax number is 716.687.2083. We will work with you to achieve the best healthcare for your child. We look forward to your arrival and meeting you.

Sincerely,

The Health Office
Kathy Faltyn
Halila Reisdorf

The Gow School

MEDICAL FORM

* Please attach a copy of the front and back of your insurance card *

Student's Full Name _____ Date of Birth _____

Father's Name _____ Cell # _____ Home # _____ WK# _____

Mother's Name _____ Cell # _____ Home # _____ WK# _____

Parent's Billing Address: Street _____

City _____ State _____ Zip Code _____ Country _____

Parent or Guardian E-mail Address _____

Emergency Contact _____ Emergency # _____

Family Medical and Hospital Insurance _____

Subscriber's Name _____ **Subscriber Date of Birth** _____

Insurance Company _____

Insurance Company Mailing Address _____

Member ID# _____ Group # _____ Effective Date _____

Type of Policy _____ Riders _____

Prescription Yes ☐ No ☐

ALL students, including Summer Program students, must have Health Insurance.

Any phone calls must be made to your insurance provider are understood to be the parent's responsibility.

Authorization for Treatment and Ongoing Health Care

I hereby request and authorize The Gow School to administer to the above - named participant under the supervision of a legally qualified nurse, medications which have been prescribed by a physician.

This health history is correct so far as I know, and the person listed above has permissions to engage in all prescribed activities except as noted. I hereby give The Gow School permissions:

1. To provide ongoing health care
2. To select medical personnel and to order X-rays, routine tests, treatment, to release any record necessary to continue treatment.

Emergency authorization for treatment:

In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by The Gow School to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use outside of campus.

This authorization is effective from June 1, 2021 to August 15, 2022. I understand that I may terminate this authorization at any time by notifying The Gow School in writing (return receipt requested)

Parent or Guardian Signature _____ Date _____

* Please attach a copy of the front and back of your insurance card *

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER

STUDENT INFORMATION

Name:	Sex ☐ M ☐ F	DOB:
	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: _____
Seizure ☐ 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

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

☐ HENT	☐ Lymph Nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations

Diagnoses/ Problems (List)	ICD- 10 Code

☐ Additional Information Attached

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**

☐ **No Non-Contact Sports** — **Includes**: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **Other Restrictions** — **Includes:** archery, badminton, bowling, cross country, fencing, golf, gymnastics, rifle, skiing, swimming and diving, tennis, and track and field

☐ Accommodations: Use additional space below

☐ Brace*/ Orthotic ☐ Colostomy Appliance ☐ Hearing Aids
☐ Insulin Pump/ Insulin Sensor ☐ Medical/ Prosthetic Device* ☐ Pacemaker/ Defibrillator
☐ Protective Equipment ☐ Sport Safety Goggles ☐ Other:

Explain_____

MEDICATIONS

☐ Order Form for Medication(s) Needed at School Attached

List Medications taken at home:		

IMMUNIZATIONS

☐ Record Attached Received Today ☐ Yes ☐ No

Medical Provider Signature	Date:
Provider Address:	Stamp:
Provider Name (*please print)*	
Phone:	
Fax:	

Please Return This Form to The Gow School When Entirely Completed

The Gow School

Check one box and sign below.

☐ My child has had the meningococcal conjugate vaccine (MCV4), for example Menactra or Menveo.

Date received:_____

Note: The Centers for Disease Control and Prevention recommend two doses of MCV4 for all adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____

(Parent / Guardian)

Student's Name_____ Date of Birth:_____

The Gow School

Medication Delivery Information for Parents

Dear Parent or Guardian, July 2021

It is required that both the health care provider and parent signature is needed before any prescription or over the counter (OTC) medication is administered. Although this may cause some inconvenience, we feel that this policy is best for the continued protection of your child and must be followed. If we do not have your written permission, and the written permission of your physician, the medication will not be given.

- Parents/guardians are responsible for having medications delivered directly to the school in a properly labeled original container by an adult, unless student has a health care provider attestation to carry and use their medication independently.
- Please bring all medication directly to the school health office.
- If your child has any allergy that requires an epi-pen please have your doctor fill out the allergy action plan.
- If your child has seizures, please have your doctor fill out the seizure action plan.
- If your child's health care provider decides your child can carry and use their diabetes, asthma or epinephrine auto-injector medication independently and you wish them to do so, they must put in writing (attest) that your child can do so safely. We have a form they can use to provide this information if they wish.

Medication forms are available on our website or may be obtained from the Health Office.

If you need to make special arrangements to drop off medication, please call to make these arrangements.

Thank you in advance for your cooperation.

Kathy Faltyn R.N.
Director of Health Services
kfaltyn@gow.org
716.687.2084

The Gow School

Over the Counter Medication Consent Form

To request that The Gow School administer any over the counter (OTC) medication to your child, the following is required:

- The physicians signed and dated authorization for selected medication at school.
- Parents signed and dated authorization to administer selected medication at school.
- Physician's directions, if differing from manufacturer's instructions.
- Annual renewal of authorization and immediate notification, in writing, of changes.

Students Name _____ DOB _____/_____/_____

Topical

- Triple Antibiotic Ointment
- Hydrocortisone Cream 1% for itching
- Burn Gel for minor burns
- Medicaine Swabs Sting & Bite Relief
- Zanfel for poison ivy, oak & sumac
- Biofreeze for muscle aches
- Chap Stick
- Refresh eye drop for dry eyes
- Sun Screen for prevention of sunburn
- Insect repellent for prevention of bug bites

Oral

- ***Acid Tablets*** (2) for heart burn, sour and / or upset stomach (each tablet contains Calcium Carbonate 420mg). Adults and children 12 years and older take 2 tablets every 2 to 3 hours as symptoms occur. Do not take more than 19 tablets in 24 hours. Do not use for more than two weeks.
- ***Benadryl (Diphen) (Dipehnhydramine)*** 25mg caplet for hay fever, runny nose, sneezing, itchy watery eyes. Adults and children 12 years and older take 1 to 2 caplets every 4 to 6 hours as needed. Do not take more than 12 caplets in 24 hours. Do not give to children under 12.
- ***Cold Relief tablets*** (2 tablets per pack) for temporary relief of cold symptoms (each tablet contains Tylenol 325mg, Dextromethorphan HBr 15mg, Guaifenesin 200mg, Phenylephrine Hcl

5mg). Adults and children 12 years and older take 2 tablets every 6 to 8 hours as needed, do not take more than 8 tablets in 24 hours. Do not give to children under 12 years of age.

- ***Cough drops*** for coughing.
- ***DayQuil liquid caps Cold&Flu*** for headache, fever, sore throat, minor aches & pains, nasal congestion, cough due to colds. Adults and children12 years and over, take 2 liquid caps every 4 hours.
- ***Desenex Powder*** for athlete's foot (Miconazole nitrate 2%). Apply twice a day for up to four weeks.
- ***Ibuprofen (Advil, Motrin)*** 200mg for minor aches & pains. Adults & children 12 years and over, take 1 tablet every 4 to 6 hours to not exceed 6 tablets in 24 hours.
- ***Loratadine (Loratamed)*** 10mg tablet for hay fever, runny nose, itchy, watery eyes, sneezing. Adults and children 12 years and older 1 tablet daily. Do not give to children under 12.
- ***Midol Complete Gelcaps*** (2) for symptoms associated with menstrual periods (each gelcap contains 500mg Acetaminophen, 60mg Caffeine, 15mg Pyrilamine). Adults and children 12 years and older, take 2 gelcaps every 6 hours as needed. Do not exceed 6 gelcaps per day.
- ***Benzocaine*** (Orosol Gel 20%).
- ***Phenylephrine Hcl*** (Medi-Phenyl) 5mg tablet for nasal congestion & pressure. Adults and children 12 years and older take 2 tablets every 4 hours as needed. Do not take more than 12 tablets in 24 hours. Do not give to children under 12 years old.
- ***Robafen DM Cough Formula*** for cough (Dextromethorphan HBr 20mg, Guaifensin USP 200mg per 10ml). Adults and children 12 years and older 2 tsp every 4 hours. Do not use on children under 12 years old.
- ***Throat lozenges*** for sore throat.
- ***Tylenol (Acetaminophen)*** 325mg for aches & pains, fever reducer. Adults and children 12 years and overtake 2 tablets every 4 to 6 hours while symptoms last. Not to take more than 12 tablets in 24 hours. Children 6-11 years take 1 tablet every 4 to 6 hours while symptoms last. Do not take more than 5 tablets in 24 hours.
- ***Zyrtec 10mg tablet (Cetirizine)*** for relief of symptoms due to hay fever. Adults and children over 6 years, take 1 tablet once daily. Do not take more than one 10mg tablet in 24 hours.

Parent/ Guardian Signature_____ Date: _____

Physician's Signature _____Date: _____

Physician's Printed Name_____Date: _____

Physician's Address: _____

Physician's Phone _____ Fax:_____

The Gow School

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed by Parent

Student Name: _____ DOB: _____

Grade: _____

I request the school nurse give the medication listed on this plan or trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Email **Phone Where We Can Reach You** ☐ **Check if Cell**

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

_____

Email

Stamp

Return to:

The Gow School Health Office

kfaltyn@gow.org

716.687.2084

The Gow School

REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ DOB: _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

Return to:

The Gow School Health Office
kfalytn@gow.org
716.687.2084

COMPLETE THIS PAGE IF YOUR CHILD REQUIRES MEDICATION FOR AN ALLERGIC REACTION

Student's Name _____ Date of Birth: _____

ALLERGY TO: _____

Asthmatic ☐ Yes* ☐ No * Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms	Give Checked Medication (To be determined by physician authorizing treatment)	
• If a food has been ingested but no symptoms	☐ Epinephrine	☐ Antihistamine
• Mouth itching, tingling, or swelling of the lips, tongue mouth	☐ Epinephrine	☐ Antihistamine
• Skin hives, itchy, rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• Other_____	☐ Epinephrine	☐ Antihistamine
• If reaction is progressing (several of above areas affected) give	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™.03mg Twinject™0.15 mg

Antihistamine: give _____

Medication/dose/route

Other: give _____

Medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad:_____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency Contacts

Name	Relationship	Phone Number

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/ Guardian Signature: _____Date: _____

Doctor's Signature: _____ Date: _____

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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