HORACE MANN SCHOOL

ANNUAL STUDENT MEDICAL FORM

PARENT PAGE

*Current Grade: ____________

Student Legal Name:__________________________________ Preferred Name:________________ Date of Birth:___________

Sex assigned at birth: M__ F__ Intersex*__

Describes a condition in which a person is born with a sex that doesn't fit the typical definitions of female or male due to genetic, hormonal or anatomical differences.

Gender Identity: Girl___ Boy___ Trans Boy___ Trans Girl___ Non-Binary___ Genderfluid___ Other _________

Student's affirming pronouns: She/Her___ He/Him ___ They/Them___ Other__________

Home Address:____

Home Phone:___________________________

Parent/Guardian 1 Name:_____________________________________ Work/Cell Phone:______________________________

Parent/Guardian 2 Name:_____________________________________ Work/Cell Phone:______________________________

Parent Email Address(es):____

Emergency Contact Name:______________________________ Emergency Contact Phone:_____________________________

Physician Name:______________________________________ Physician Phone:_____________________________________

Medical History (indicate year if appropriate)

Asthma_______________________ Cancer______________________ Diabetes___________________

Allergies (specify)______________ Injuries/Fractures_____________ Vision Problems_____________

Food Intolerance_______________ Seizures/Convulsions__________ Hearing/Speech______________

Hospitalizations________________ PT/OT______________________ Other______________________

Emergencies

In an emergency situation every effort will be made to immediately contact the parent or family doctor. In the event neither can be reached promptly, the school needs your permission to proceed with emergency care in instances where delay might compromise your child's wellbeing. Horace Mann School uses the 911 Emergency Medical Service. I hereby grant to Horace Mann School Medical and Administrative Staff the authority to obtain any necessary medical treatment for my child with the understanding that the family will be notified as soon as possible. I also give my permission to Horace Mann School to release medical information as appropriate to school faculty/staff.

*Parent/Guardian Signature: ____ *Date: ______________________________

*In addition to the above signature, a second parental signature is required on the Medication Permission Page along with the medical provider's signature.

*Return all forms to the appropriate Horace Mann School Division Nurse.

Nursery Division

Nurse Irene Pinzon
Phone: (212) 369-4600 ext 43

Irene_Pinzon@horacemann.org

55 East 90th Street
New York, NY 10128
Fax: (212) 722-2460

Lower Division

Nurse Kathleen Sheridan
Phone: (718) 432-3353

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4440 Tibbett Avenue
Bronx, NY 10471
Fax: (718) 432-3630

Middle and Upper Divisions

Nurse DeAnna Cooper
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Nurse Nancy Jensen
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Bronx, NY 10471
Fax: (718) 432-3604

HORACE MANN SCHOOL

ANNUAL STUDENT MEDICAL FORM

MEDICATION PERMISSION PAGE

Student Legal Name:__________________________________ Preferred Name:________________ Date of Birth:___________

NON-PRESCRIPTION MEDICATIONS

Only the school's Registered Nurse may administer the medication(s) below, in the school setting, based on the R.N.'s assessment. The one exception is sunscreen. Students may carry and use topical sunscreen provided by a parent. Any student who is unable to physically apply sunscreen may be assisted by unlicensed personnel.

YES	NO	NAME OF MEDICATION	DOSING AND INDICATIONS	
		Acetaminophen (Tylenol)	As per label, every 4 hours as needed	General pain *associated with* headache, toothache, orthodontics, injury, menstrual cramps, fever etc.
		Antiseptic spray	Spray as needed on affected area	Skin antisepsis
		Benzocaine oropharyngeal (Anbesol, Oragel, Orabase etc.)	Apply QID	Relieve tooth pain and mouth sores
		Diphenhydramine (Benadryl) Topical Cream or Oral	As per label, every 6-8 hours as needed	Allergic Reaction Only: hives, rash, anaphylaxis. *NOT available for daily management of seasonal allergy symptoms*
		Calagel	As per label	Itchiness
		Calcium Carbonate (TUMS)	As per label, as needed	Upset stomach, indigestion
		Claritin (Lorantadine) or Zyrtec (Cetirizine)	10mg daily	Relieve allergy symptoms *NOT available for daily management of seasonal allergy symptoms*
		Cough drops *(6 years & older)*	Follow label instructions	Reduce coughing, relieve sore throat
		Hydrocortisone Cream	Apply 2-3 times daily	Skin irritation, itching
		Ibuprofen (Motrin)	As per label, every 6-8 hours as needed	General pain *associated with* headache, toothache, orthodontics, injury, menstrual cramps, fever etc.
		Medicaine Swab Sting & Bite Relief (swabs, wipes, or spray)	As per label	For pain associated with bug bite.
		Saline/ Refresh eye drops	As per label	Treat eye irritation
		Sunscreen **provided by parent*	As per label **Students may carry and use topical sunscreen provided by a parent. Any student who is unable to physically apply sunscreen may be assisted by unlicensed personnel**	To prevent sunburn and protect from UV rays.
		Triple antibiotic ointment	Apply 2-3 times daily	Treat minor cuts and abrasions

ALL OTHER OTC or PRESCRIPTION MEDICATIONS

Please list ALL OTHER OTC or PRESCRIPTION MEDICATIONS the child will be taking during the school day and/or on overnight trips. You must provide the medication in the original pharmacy container.

*For Epi-Pens, inhalers or nebulizers, diabetes or seizure medications an emergency care plan must be filled out by the medical provider

MEDICATION	DOSAGE & ROUTE	FREQUENCY	INDICATION

I hereby give my permission for the school nurse to administer the over the counter medications and the prescription medications listed above that will be required during the school day and/or on overnight trips.

*Parent/Guardian Name:____

*Parent/Guardian Signature:____ *Date:____________________

*Medical Provider Name:____

*Medical Provider Signature:____ *Date:___________________

*Medical Office Phone Number:____ *License # / NPI #:__________

HORACE MANN SCHOOL

ANNUAL STUDENT MEDICAL FORM

CARDIAC RISK ASSESSMENT PAGE – GRADES 6-12 ONLY

Student Legal Name:_________________________________ Preferred Name:_______________ Date of Birth:__________

Date of Exam: ____________________________________

TO BE COMPLETED BY STUDENT AND PARENT/GUARDIAN	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _________________________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catscholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in you family had an unexplained fainting, unexplained seizures, or near drowning?		

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________
____

☐ Not Cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ____

Reason ____

Recommendations____

I have examined the above named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents/guardians. If conditions arise after the student has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

*Medical Provider Name:____

*Medical Provider Signature:______________________________________ *Date:___________________

*Medical Office Phone Number:____________________________________ *License # / NPI #:__________

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex ☐ Female ☐ Male	Date of Birth (Month/Day/Year) ___ ___/___ ___/___ ___ ___ ___

Child's Address	Hispanic/Latino? ☐ Yes ☐ No	Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough	State	Zip Code	School/Center/Camp Name	District Number __ __ __	Phone Numbers Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent	Last Name	First Name	Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)*** ☐ None ☐ Yes *(list below)*

______

PHYSICAL EXAM **Date of Exam:** ___/___/___

Height	______ **cm**	(___ ___ %ile)
Weight	______ **kg**	(___ ___ %ile)
BMI	______ **kg/m²**	(___ ___ %ile)
Head Circumference *(age ≤2 yrs)*	______ **cm**	(___ ___ %ile)
Blood Pressure *(age ≥3 yrs)*	______ / ______	

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	____/____/____ ____/____/____	______ µg/dL ______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	____/____/____	☐ At risk *(do BLL)* ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	____/____/____	______ g/dL ______ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ____/____ Left ____/____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ______	___/___/___	______	___/___/___

Report only positive immunity:

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

______ ______
______ ______
______ ______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature	Date Form Completed ____/____/____	**DOHMH ONLY** **PRACTITIONER I.D.** ☐☐☐☐☐☐
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State	**TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s) *Comments:*
Facility Name	National Provider Identifier (NPI)	Date Reviewed: ____/____/____ **I.D. NUMBER** ☐☐☐☐☐☐ REVIEWER:
Address / City / State / Zip		
Telephone / Fax / Email		**FORM ID#** ☐☐☐☐☐☐☐☐☐☐

Horace Mann School

Bronx, NY

Medication Authorization Form - Physician/Parent/Guardian Signature for Self-Administration/Self-Possession

If it is medically necessary for a child to carry and self-administer his/her/their own medication, the child must hand in this form with parts A and B fully filled out. Part C will be completed in the Horace Mann School nurse's office with the child. The child must be able to answer the questions in Part C or he/she/they will not be permitted to carry or administer his/her/their own medication; this is for the safety of the child and others. This form must be filled out in addition to the parent/guardian and prescriber's normal authorization form for administration of medication in school.

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her/their person to allow for immediate and self-determined administration. For medication other than inhalers, only that day's supply of medication is to be carried unless the student is approved to participate in an trip that takes place over the course of multiple days. The school recommends that spare medication, properly labeled in its original container, be kept in the office in case the student runs out of or forgets the medication. Administrators and appropriate teachers are informed on a need-to-know basis that the student is permitted to self-possess/self-administer medication.

It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her/their medication will be rescinded and disciplinary action may follow. The privilege to carry and self-administer any medication is at the sole discretion of the school.

Student Name:____________________ Birthdate:________ School Year:__________ Start Date:________ Stop Date:________

A. To be completed by Physician

	Medication Name	**Dose**	**Time to be Given**	**Form/Route[1]**	**Side Effects**	**Adverse Reactions**
1						
2						
3						

[1]Route - oral (pill/capsule/chewable/liquid) - inhaled (inhaler, nebulizer) - topical skin application - topical (eyedrop, ointment) - topical ear drop - other (list)

List minimal frequency between doses (especially if PRN):____________________

If PRN (as needed), list symptoms/conditions under which medication is to be given:____________________

The student is capable of (check all that apply) ☐ self-administering ☐ self-possessing the above medication(s).

____________________ ________________ ____________________

Physician Signature | Date | Physician Printed Name

B. To be completed by Parent/Guardian

I request and give permission for my child ______________ to ☐ self-administer ☐ self-possess the above medication(s) according to school policy, and for the physician's staff and school staff to share information regarding my child's medication needs.

____________________ ____________________ ____________________

Parent/Guardian Signature | Date | Parent/Guardian Printed Name

(OVER)

Student Name: ____

C. To be completed by Horace Mann School Nurse with Student

Student responsibilities for carrying and using medication observed:

Yes	No	Student is consistently able to:
☐	☐	Name the medication
☐	☐	Identify the correct medication
☐	☐	Identify the purpose of the medication
☐	☐	Know the correct dosage of the medication
☐	☐	Identify the time(s) the medication is to be administered
☐	☐	Describe what will happen if the medication is not taken
☐	☐	Has the ability to refuse to take the medication if he/she/they have any concerns
☐	☐	Demonstrate the correct use and administration
		In addition,
☐	☐	The student realizes his/her/their responsibility in carrying his/her/their medication(s) and agrees not to share the medication(s) with others.
☐	☐	The student agrees to come to the nurse's office immediately with any questions/concerns/adverse side effects.

______________________________ ______________________________ ______________________________

Student Signature Horace Mann School Nurse Signature Date

I understand that:

1. Sharing my medication with another person is prohibited, dangerous, and will result in expulsion.
2. I must carry the medication in its original properly-labeled prescription container or over the counter container.
3. I must take the medication only at the prescribed time(s), frequency and dose.

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardian, and the privilege of self-administration/self-possession will be denied, with the possibility of disciplinary action.

______________________________ ____________________

Student Signature Date

Any questions pertaining to this form or the completion of this form are to be directed to the nurse responsible for the form. Horace Mann School's nurses can be reached at the following points of contact:

Irene Pinzon, Nursery Division

irene_pinzon@horacemann.org
(212) 369-4600 x43
Fax (212) 722-2460

Kathleen Sheridan, Lower Division

LDNurse@horacemann.org
(718) 432-3353
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DeAnna Cooper, Nancy Jensen
Middle & Upper Divisions
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DeAnna Cooper (718) 432-4112
Nancy Jensen (718) 432-4113
Fax (718) 432-3604

Nurse at Dorr

860-868-2230