EDGEMONT JUNIOR-SENIOR HIGH SCHOOL

200 WHITE OAK LANE
SCARSDALE, NEW YORK 10583

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

Dear Parent/Guardian:

In accordance with 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. Please remember that if your child participates in interscholastic sports their physical expires **one year** from the date of their last examination.

In this packet you will find:

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 the attached form. ****No other forms or attachments will be accepted.**

Medication Authorization Form : To comply with New York State Education Law, *this form must be completed by **both** a parent and physician prior to administering any medication to your child during school hours.* This is required for any prescription medication, or OTC, Over the counter medication. All medications must be delivered by a parent to an authorized school official, in the original container with your child's name.

** **For EpiPen, Inhalers, or diabetic medications, please contact the nurses directly.**

Dental Form ***(required)***: Completed at the most recent appointment during this school year.

Forms are available on the EHS website in the School Info tab and Quicklinks

For sports registration and information please call the Athletic Director's office at 914 725-1500 ext. 1592 or 1570. Also please read the Athletic page on EHS website.

Absences must be reported to the Attendance Clerk at **Email** Attendance@edgemont.org or call 914 725-1543 by **9:00 a.m.**

Please do not hesitate to contact us if you have any questions. We are looking forward to getting to know your child and helping to make his or her year a successful one.

Sincerely,

Kathy Burbage R.N.
Kathy Burbage R.N.

Karen Lacerra
Karen Lacerra R.N.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When 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:

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 **delivered** to the school nurse **by the parent. or parent representative.** (Advil, Tylenol, and Benadryl tablets are the only medications stocked in school. Any other medications, including liquid and chewable, must be provided by you.)

3. 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.

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

5. Inhalers and Epipens are the only medications that students may carry, and only if the school nurse has on file a physician's order and a self administration waiver. This form is available upon request and on the healthoffice website.

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 Ms.Kathy Burbage R.N. or Ms. Karen Lacerra R.N. our school nurses, for further information and forms.

Sincerely,

Kyle Hosier

Kyle Hosier
Principal

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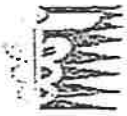

MEDICATION AUTHORIZATION FORM

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