

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 Parents/Guardians:

Please use this packet of forms for your rising 8th, 10th and 12th grade students. If your child participates in interscholastic sports, their physical exam expires **one year** from the date of their last examination. You can view the most current exam date we have on file for your child by logging into your Family ID registration portal.

In this packet you will find:

1. **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 this form. ** No other forms or attachments will be accepted.
2. **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 non-prescription (OTC). All medications must be delivered by a parent to an authorized school official, in the original container with the child's name.

**For EpiPen, inhalers or diabetic meds., please contact the nurses directly

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. 1592/1570. You can also get information from the Athletic page on the EHS website.

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

Please feel free to contact us if you have questions or concerns.

Sincerely,


Kathy Burbage R.N.


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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:
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SCREENINGS

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

Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>

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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail Referral <input type="checkbox"/> Yes	<input type="checkbox"/>

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

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
<input type="checkbox"/> Confirmed free of communicable disease during exam	<input type="checkbox"/> Record Attached <input type="checkbox"/> 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
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	<u>DOSAGE</u>	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	<u>DOSAGE</u>	Schedule & Indications	Comments

Physician Signature: _____ Date: _____

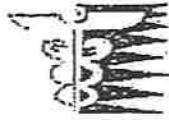
License #: _____ Phone #: _____

**** 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 (Section 136.3) 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