



### **KINDERGARTEN HEALTH PACKET:**

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**EDGEMONT UNION FREE SCHOOL DISTRICT**

**Business Office  
300 White Oak Lane  
Scarsdale, New York 10583**

**Kenneth R. Hamilton, Ed. D., Superintendent of Schools  
[khamilton.edgemont.org](http://khamilton.edgemont.org)  
(914) 472-7768**

Dear Edgemont Families of Incoming Kindergarten students,

I am excited about the anticipation of welcoming our class of 2036. Can you imagine! I know it seems like an eternity away, but as a father of two boys, the time goes by much faster than you think. I strongly believe that college preparation begins in kindergarten. One of the most important decisions we make as parents is how to ensure that our children get the absolute best education possible, and that they grow up with the tools they need to navigate a very complex world. Undoubtedly, this was a factor in your decision of where you choose to live and raise your family.

Edgemont is an exceptional school district with tremendous opportunities for our students to excel academically, socially, and emotionally. However, we are also committed to ensure that in addition to providing our students with the building blocks for a firm foundation, upon which their educational experiences emerge, we want our students to be kind, thoughtful, and respectful people who grow up to be contributing members of a rapidly growing, inclusive society.

Our kindergarten program is robust. Our teachers are masterful at the implementation of these standards, managing expectations, and meeting national benchmarks. Additionally, we have worked to ensure that we have processes in place that will help us identify students who may require supplemental or enrichment services as soon as possible. We know that the earlier we find and identify students' needs, the more likely we will be able to either remediate or advance student learning experiences.

Edgemont is committed to some of the best educationally sound, research-based instructional practices in the state. However, what really makes Edgemont special are the members of the educational community which includes faculty, students, and their parents. These stakeholders form partnerships that enrich the learning experience. Students whose parents are actively involved in their children's educational experiences typically excel academically and socially, particularly at these primary levels where their excitement for learning is instinctive and boundless. All incoming kindergarten students are screened to help us identify students' strengths and opportunities to maximize their learning outcomes.

As with all public schools, there are some required vaccinations necessary upon enrollment. You can find that information in this packet or on our website ([www.edgemont.org](http://www.edgemont.org)) for your reference.

In closing, I assure you that if you will partner with us, your child's experience in the Edgemont Union Free School District will be nothing short of extraordinary. Please be on the lookout for information from your respective elementary school principal about open house and meet and greet opportunities. I look forward to seeing you soon as this extraordinary journey begins.

Yours for the sake of all Children,

  
Dr. Kenneth R. Hamilton



Edgemont School District  
Greenville School  
Seely Place School  
Scarsdale, New York 10583

Dear Parents and Guardians of our Greenville and Seely Place Students,

Welcome to Edgemont! We are thrilled that you are joining our community and we look forward to getting to know your children and you over the years to come!

Attached you will find a packet of required medical forms to fill out as well as information about our Health Office practices and requirements. Please read everything thoroughly and contact our school nurses if you have any questions.

We would like to stress a particularly important piece of information which is that students must be completely up-to-date with all required immunizations prior to the first day of school or they will not be permitted to attend class. This packet contains a chart with the required immunizations; please consult with your pediatrician to confirm that all have been administered. We are all eager to meet all of our new students on the first day of school, so we strongly encourage you to ensure that all of your child's immunizations are current so that he/she can get off to a great start!

In addition, all students must have a current medical exam completed within the first two weeks of school. We encourage you to have this done prior to the start of school in order to ensure that there is no disruption to your child's school attendance.

We hope that your transition to Edgemont is a smooth one and wish you all the best in your years with us.

Sincerely,

*Marisa Ferrara*

Marisa Ferrara  
Greenville School Principal

*Eve Feuerstein*

Eve Feuerstein  
Seely Place School Principal





**Health Office**  
Edgemont School District  
Greenville School  
Seely Place School  
Scarsdale, New York 10583

### *New Student Welcome Packet*

Hello Families,

Welcome to Edgemont School District. We are very excited for you to join our community! Please read the following information to ensure that your child's transition will be a smooth one.

- If you are transferring to Edgemont from **within** New York State, we ask that you submit a copy of your child's current Health Appraisal (physical exam) and immunization record. This must be from within the last year. All immunizations must be up to date before the start of school. New York State requires all students to be immunized before they attend school. The only exceptions are students with medical exemptions. Please note, if you are unable to provide this information, your child will be excluded from school.
- All out of state incoming students will need to have a completed Health Appraisal (physical exam) administered by a New York State physician within two weeks from the start of school. If you are out of the country, you will be granted a 30 day grace period from the start of school to complete this process.
- A dental examination is required during the school year.
- You will only need to fill out the "Emergency Health Forms" if your child has a severe food or insect allergy. If your child requires daily or as needed medication, you will need to provide a medication authorization form filled by your pediatrician and also signed by a parent.
- Our school physician is Dr. Eric Small who is located at 220 North Central Avenue, Hartsdale 914-666-7900. Please call our office for a list of other physicians in the area.
- If you have any medical concerns or issues, please speak with the Health Office before your child starts school. If your child requires daily or as needed medication, you will need to provide a medication authorization form filled by your pediatrician and also signed by a parent.
- We have included a copy of our Health Office policy for your review.

The office hours for the nurses office at both schools are 8:00 am to 3:30 pm. The phone number for the Greenville Health Office is 914-472-7764 and the fax number 914-472-3161. The phone number for the Seely Place Health Office phone is 914-472-8040 and the fax number 914-472-3512. We can also be reached by email if there are any questions and/or concerns.

Thank you very much.

The Greenville and Seely Place School Nurses





## **Health Office**

Edgemont School District  
Greenville School  
Seely Place School  
Scarsdale, New York 10583

### ***Elementary School Health Office Policy***

In order to best care for your children, we ask that you follow the reminders we have listed below:

1. If your child is going to be LATE or ABSENT, please email the school attendance emails and the teacher on the first morning of an absence and on each succeeding morning that the student is not in school. Please always include the reason for the absence or tardiness. All absences or tardies should be reported before 10:00 AM. If you know of an extended absence ahead of time then please email as soon as you know.

**The attendance emails are as follows:**

Seely Place Elementary [seelyattendance@edgemont.org](mailto:seelyattendance@edgemont.org)

Greenville Elementary [greenvilleattendance@edgemont.org](mailto:greenvilleattendance@edgemont.org)

**If your child is LATE to school, follow the directions below:**

Your child should come into school and go to the health office for a late pass.

**If your child is leaving school EARLY, please email your child's teacher and the main office:**

Seely Place email: [mavitabile@edgemont.org](mailto:mavitabile@edgemont.org)

Greenville email: [mdenet@edgemont.org](mailto:mdenet@edgemont.org) or [abybel@edgemont.org](mailto:abybel@edgemont.org)

Once you arrive to pick up your child, please inform the front office staff that you are here to pick up your child. Please sign them out of school using the binder in the front vestibule.

If your child returns to school before the end of the day, please escort them back into the building. Once inside, please sign them back into school in the book in the front vestibule.

2. Please have your child stay at home if they are not feeling well. If they go to school, their condition may worsen and their illness may spread to others. A child may return to school after all symptoms are gone and they are diarrhea/vomit/fever free for 24 hours. This means, for example, that if a child is sent home at 10:00am on a Monday, the earliest he/she may return to school after being symptom free for 24 hours would be Wednesday. Please report to our office any confirmed diagnosis of any contagious illness such as strep throat, Covid 19, conjunctivitis, fifth disease, flu, etc.. Also, please report any case of head lice.
3. Please keep all medical information up to date and notify the health office with any new health updates for your child including diagnosis, treatments, medications or any other pertinent medical information that we should be aware of so that we can best support your child at school.
4. **Health examination certificates are required in Grades K, 1, 3 and 5** as per New York State Department of Health but we encourage you to send in updated health certificates yearly for all

grades. For those who have not sent in updated health certificates and immunization records for their children, please send an updated health appraisal and immunization record as soon as you can. Please note that the health certificates must be filled out on the **NYS approved form** (NYC forms cannot be accepted) which can be found on our website and contains height, weight, vision, hearing and scoliosis screenings.

5. If a student needs to be excused from Physical Education (PE) and/or other activities/recess for more than 1 day, they must submit a note from their doctor explaining why and for how long since PE is a NYS mandated class and requirement. A medical clearance note will be required to return to PE/recess/activities after any injury or activity restriction.
6. The Health Offices will be conducting vision, hearing and scoliosis screenings for those students who have not had them completed with their health providers or the information was not included on the physical exam form submitted to school and as needed. The upcoming screenings will be completed throughout the school months. Please note that the parent/guardian will only be notified of the results of any screenings that require a follow up with a health care provider. This notification will be provided in writing to the student's parent/guardian and to the student's teacher while the student is enrolled in school. If you have any questions regarding the health appraisals or screenings, please do not hesitate to reach out.
7. New York State has regulations for the administration of medication in school. The following steps should be taken if your child is in need of any medication, including over the counter medication during the school day.
  - a. We must have on file a written request signed by you and your physician. This form is available on the school website.
  - b. All medication must be delivered to the Health Office by the parent.
  - c. The medication must be in the original container, as it is received from the pharmacist. Over the counter medication must be in the original container and be labeled with the name of the child and description of the dosage.
  - d. The medication must be kept in the Health Office.
  - e. Students are not allowed to carry any medications on the school premises.

Finally, please remember to notify us when there is a change in your emergency or work telephone numbers. In addition, please keep in close contact with the school if there are any significant changes in your home. Thank you for your cooperation.

Aine O'Sullivan, RN Greenville School Nurse  
914-472-7764 or [aosullivan@edgemont.org](mailto:aosullivan@edgemont.org)

Julia Firer, RN Seely Place Nurse  
914-472-8040 or [jfirer@edgemont.org](mailto:jfirer@edgemont.org)

Anneka Ward, RN Float Nurse  
[anward@edemont.org](mailto:anward@edemont.org)

## **WHEN TO KEEP YOUR CHILD HOME**

**CONJUNCTIVITIS (PINK EYE):** Redness and significant discharge from the eye, may indicate "pink eye." If your child is diagnosed with bacterial conjunctivitis, he or she may return to school after your child has received medication (eye drops) for 24 hours.

**COUGH/COLD SYMPTOMS:** If your child is not feeling well or has a significant cough that makes him or her feel uncomfortable or disrupts the class, it is important to keep them home to recover and possibly be evaluated by your pediatrician. Coughs can be symptoms of mild colds or more significant illnesses including covid, RSV, bronchitis, flu, or pneumonia.

**COVID-19:** If your child is positive for Covid 19, please notify the Health office. Your child will need to stay home and isolate for 5 days, starting with the first day of symptoms or date of positive test if asymptomatic, which is day 0. After completing isolation, your child will need to wear a mask when they return for an additional 5 days and can remove their mask after day 10. Your child must also be fever free without the use of medications and other symptoms improving and minimal to return. Testing is still recommended for people with symptoms of COVID-19 as soon as possible after symptoms appear. However, quarantine is no longer recommended for people who are exposed to COVID-19.

**DIARRHEA or VOMITING:** Your child needs to be kept home for at least 24 hours after the last episode of diarrhea and/or vomiting (without medication). For example, if your child is sent home on a Monday, the earliest he/she may return to school after being symptoms free for 24 hours would be Wednesday.

**FEVER:** If your child has a temperature of 100.4 degrees or higher, he/she must stay at home. Your child must be fever free for 24 hours (without medication) before returning to school. Please note that the time starts 8 hours after the last dose of fever reducing medicine, not the actual fever itself.

**FIFTH DISEASE:** Fifth Disease is a very contagious viral illness spread by coughing and sneezing. The initial symptoms are usually mild and may include fever, runny nose, and headache. After several days, the child may develop a red rash on the face that resembles slapped cheeks. This illness is most contagious prior to the rash presentation. Once the rash develops, it is fine to return to school if there is no fever for 24 hours and no other significant symptoms. While fifth disease is a relatively mild illness, it can cause serious complications to people with weakened immunity and during pregnancy. Therefore, it is very important that you contact the health office if your child has been diagnosed with this illness.

**LICE:** If your child is diagnosed with lice, please contact the Health office. It is advised that your child be treated as soon as possible to avoid further spread to other children in the class. Your child must be cleared by the Health office nurse before returning to school.



## **WHEN TO KEEP YOUR CHILD HOME (continued)**

**RASH:** If your child develops a skin rash it is important to consult with your doctor. Some skin rashes can indicate infectious illness and other rashes may require antibiotic treatment. Some rashes that should be checked before sending your child to school include:

- Honey crusted sores which may indicate impetigo.
- Rash in various stages including boils, sores, and bumps that may indicate chicken pox.
- Significant rash accompanied by other symptoms of illness such as fever.

**RSV:** Respiratory syncytial virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. Symptoms of RSV infection usually include: runny nose, decrease in appetite, coughing, sneezing, fever, wheezing. These symptoms usually appear in stages and not all at once. Most RSV infections go away on their own in a week or two. RSV can spread when an infected person coughs or sneezes or touch a surface that has the virus on it, like a doorknob, and then touch your face before washing your hands. People infected with RSV are usually contagious for 3 to 8 days and may become contagious a day or two before they start showing signs of illness. A child can return to school when he/she cleared by their medical provider and the child is fever free for 24 hours without fever reducers (such as Tylenol / Motrin) and symptoms improving and no longer wheezing.

**SORE THROAT:** A sore throat that is severe, accompanied by a fever that persists for longer than 48 hours, or after known exposure to a confirmed case of Strep Throat should be evaluated. Other symptoms of Strep Throat can include headache and stomach upset. If your child is diagnosed with Strep Throat, he or she can return to school 24 hours after antibiotic treatment was initiated AND after your child is fever free for 24 hours.

**QUESTIONS:** If you have any questions regarding your child's health or are unsure whether you should send your child to school, please do not hesitate to contact the Health office and speak to our nurses. We welcome your communication and look forward to assisting you in your child's healthcare needs.



### Health Office

Edgemont School District

Greenville School

Seely Place School

Scarsdale, New York 10583

## Medication Authorization Form

Individualized Orders for: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergies: \_\_\_\_\_

1. Standard Over-the-Counter/PRN Medications: The following medications are the only ones available in the Health Office. For any other medications, see below. These medications will be administered at the discretion of the RN only if signed approval is indicated by **both** the student's physician and **parent**.

Drug Name	Route	Dosage	Schedule and Indications	Comments
Tylenol tablets (acetaminophen)	po		Q____ Hr. for:	
Advil tables (ibuprofen)	po		Q____ Hr. for:	
Throat Lozenges	po		Q____ Hr. for:	
Benadryl Capsules (diphenhydramine hydrochloride)	po		Q____ Hr. for:	

2. Prescription and any other Over-the-Counter Medications: Please complete with patient's current regimen for both scheduled and PRN medications.

**All 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 and Indications	Comments

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

License Number: \_\_\_\_\_

Phone: \_\_\_\_\_

**\*\* I authorize the school RN to dispense the medication prescribed by the above physician.**

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Health Office**

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***Dental Form***

Individualized Orders for: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

\_\_\_\_\_

Please have this form completed by your family dentist at the time of your child's dental examination.

\_\_\_\_\_ 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.

Additional Remarks: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Dentist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# 2023-24 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**

All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) <sup>2</sup>	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) <sup>3</sup>		Not applicable		1 dose
Polio vaccine (IPV/OPV) <sup>4</sup>	3 doses		4 doses or 3 doses if the 3rd dose was received at 4 years or older	
Measles, Mumps and Rubella vaccine (MMR) <sup>5</sup>	1 dose		2 doses	
Hepatitis B vaccine <sup>6</sup>	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine <sup>7</sup>	1 dose		2 doses	
Meningococcal conjugate vaccine (MenACWY) <sup>8</sup>		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) <sup>9</sup>	1 to 4 doses		Not applicable	
Pneumococcal Conjugate vaccine (PCV) <sup>10</sup>	1 to 4 doses		Not applicable	

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
  - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
  - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6, 7 and 8: 10 years; minimum age for grades 9 through 12: 7 years)
  - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
  - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 through 12.
  - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
  - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
  - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
  - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
  - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
  - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
  - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks)
  - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
  - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
  - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
  - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
  - d. If dose 1 was received at 15 months or older, only 1 dose is required.
  - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
  - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
  - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
  - e. PCV is not required for children 5 years or older.
  - f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: [www.health.ny.gov/prevention/immunization/schools](http://www.health.ny.gov/prevention/immunization/schools)

For further information, contact:

**New York State Department of Health  
Bureau of Immunization  
Room 649, Corning Tower ESP  
Albany, NY 12237  
(518) 473-4437**

**New York City Department of Health and Mental Hygiene  
Program Support Unit, Bureau of Immunization,  
42-09 28th Street, 5th floor  
Long Island City, NY 11101  
(347) 396-2433**

# 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"/> <b>Allergies</b>	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> <b>Asthma</b>	<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"/> <b>Seizures</b>	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> <b>Diabetes</b>	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/m<sup>2</sup>

**Percentile (Weight Status Category):** ☐ < 5<sup>th</sup> ☐ 5<sup>th</sup>- 49<sup>th</sup> ☐ 50<sup>th</sup>- 84<sup>th</sup> ☐ 85<sup>th</sup>- 94<sup>th</sup> ☐ 95<sup>th</sup>- 98<sup>th</sup> ☐ 99<sup>th</sup> and >

**Hyperlipidemia:** ☐ Yes ☐ Not Done

**Hypertension:** ☐ Yes ☐ Not Done

## PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level</b> Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$
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

Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
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☐ Additional Information Attached

\*Required only for students with an IEP receiving Medicaid



Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision Screening</b>	<b>With Correction</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
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					
<b>Hearing Screening:</b> 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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
<b>Scoliosis Screening:</b> Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process</b> <b>ONLY</b> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
<b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
<small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					

**FARE**

Food Allergy Research &amp; Education

**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No**PLACE  
PICTURE  
HERE****NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.****Extremely reactive to the following allergens:** \_\_\_\_\_**THEREFORE:**

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

**FOR ANY OF THE FOLLOWING:  
SEVERE SYMPTOMS****LUNG**Shortness of  
breath, wheezing,  
repetitive cough**HEART**Pale or bluish  
skin, faintness,  
weak pulse,  
dizziness**THROAT**Tight or hoarse  
throat, trouble  
breathing or  
swallowing**MOUTH**Significant  
swelling of the  
tongue or lips**SKIN**Many hives over  
body, widespread  
redness**GUT**Repetitive  
vomiting, severe  
diarrhea**OTHER**Feeling  
something bad is  
about to happen,  
anxiety, confusion**OR A  
COMBINATION**  
of symptoms  
from different  
body areas.

- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - Antihistamine
    - Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

**MILD SYMPTOMS****NOSE**Itchy or  
runny nose,  
sneezing**MOUTH**

Itchy mouth

**SKIN**A few hives,  
mild itch**GUT**Mild  
nausea or  
discomfort**FOR MILD SYMPTOMS FROM MORE THAN ONE  
SYSTEM AREA, GIVE EPINEPHRINE.****FOR MILD SYMPTOMS FROM A SINGLE SYSTEM  
AREA, FOLLOW THE DIRECTIONS BELOW:**

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler/bronchodilator if wheezing): \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH &amp; EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020



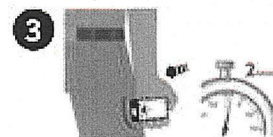


**FARE**  
Food Allergy Research & Education

## FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

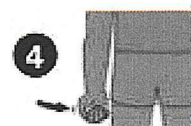
### HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



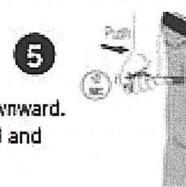
### HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



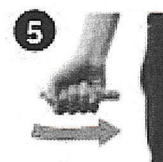
### HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



### HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



### HOW TO USE SYMJEPITM (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPITM by finger grips only and slowly insert the needle into the thigh. SYMJEPITM can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



### ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

#### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_