

ONTEORA CENTRAL SCHOOL DISTRICT

Bennett Elementary School

Boiceville, New York 12498
www.onteorak12.ny.us

Tel. (845) 657-2354
Fax (845) 657-8504

Welcome to Bennett Elementary! We can't wait to meet you!

Dear Parent/Guardian:

I have received your child's registration paperwork from our central office. If your child is not up to date on their immunizations, I have provided what immunizations they need to get before the start of school. I have included The NYS immunization requirements for the upcoming school year. Enclosed, you will find a NYS Health Examination Form that is to be filled out by their physician for September. Physicals are good for one year and must be up to date. I have also enclosed our optional dental form, and a medication form in case they will need any medication during school hours. All medication must be brought and picked up by parent or guardian to/from school. These forms are for their physician to fill out if needed, and both have a place for parent/guardian to fill out. Please return this to me as soon as you can.

I hope this letter found you healthy and well. If you have any questions, please do not hesitate to contact me at the above number or email nscanlon@onteorak12.ny.us.

Thank you!
Nara Scanlon BSN-RN

Welcome to
KINDERGARTEN

Onteora Central School District Health Services

June

Dear Parent/Guardian;

We look forward to welcoming your child back to school in September. The Health and Safety of students and staff are constantly being reviewed and updated. Our top priority is to maintain a safe and healthy environment for everyone.

Please be advised when students return in September, immunizations must be up to date, or have been approved as in process (this must follow the Advisor Committee on Immunizations Practices [ACIP] schedule). You will receive a notice from your child's school nurse if your child requires any immunizations. If your child has a medical exemption for immunization, a new request must be filled out by your child's Health Care Provider (HCP) and sent to the school for final approval each year. Please contact your child's school nurse with any questions or concerns.

All new entrants and students in grades K, 1, 3, 5, 7, 9, and 11 must have a current physical on file in the health office. This documentation, if not already submitted, is expected to be provided to the health office by September 30th. If the health appraisal is not received by September 30, the school nurse will contact you regarding a physical either with your primary care provider or with the school Medical Director. A dental certificate is recommended on all students who are required to have a current physical on file.

Please notify your school nurse of any changes to your child's health; such as new medications and new diagnoses, including COVID – 19.

Medications, prescribed or over the counter, MUST have a HCP written order for the medication to be administered at school. Students are only allowed to carry certain medications on their person. The HCP must complete the medication order form and the self-carry attestation form in order for the student to self-carry. The completed forms must be turned in to the school nurse.

Alcohol based hand sanitizers are still being utilized in school. If you do not wish for your child to use the hand sanitizer, please send a written notice to the health office that your child is NOT to use the alcohol-based hand sanitizers.

Please view and print the grade specific Health Forms available via the links on the Onteora Central School District health services webpage. If you do not have access to a printer, please email your school nurse to request hard copy of required forms via US Mail.

Sincerely,

Onteora Central School District Nurses

Nara Scanlan, RN, Bennett School
Sabrina Blakely, RN, High School
Karen Hansen, RN, Middle School
Heather Kight, RN, Woodstock School
Brianna Ashmore, RN, Bennett School (on leave)

LEGAL REQUIREMENTS

Immunizations

New York state requires the following immunizations:

- 5 DTaP Diphtheria Toxoid (only 4 if the 4th is given on or after age 4)
- 4 IPV Polio (only 3 are requires if the 3rd is given after age 4)
- 1 Tdap booster for 6th graders (after age 10)
- 2 MMR Measles, Mumps and Rubella
- 3 Hepatitis B
- 2 Varicella (chicken pox)

Health Examinations

New York State Law requires health appraisals (physical exams) for all students entering Kindergarten, Grade 1, Grade 3, Grade 5 and all CSE students. The Health Office can perform these examinations; however, your healthcare professional is recommended because he or she:

- Is familiar with your child's history.
- Can provide needed immunizations.
- Has diagnostic facilities not found in schools.
- Can immediately treat or advise you about any health conditions that might be found.

The Health Office will provide a form for your doctor to use for such an examination or you can print one from the district web site.

Dental Certificates

A dental certificate is recommended to be completed by your child's dentist and turned into the health office.

Vision and Hearing Screenings

New York State requires vision and hearing screenings for all new entrants and for Kindergarten, Grade 1, 3 and 5 and all CSE students.

The Vision screening will include a near vision, distance acuity and color perception (for new entrants only).

HEALTHY HABITS

Your children will learn if you practice healthy habits at home.

- Have a regular bedtime hour for your child. Primary grade children need at least 10 hours of sleep every night.
- Help your child start each morning with enough time to wash, eat a good breakfast and brush their teeth.
- Make sure your child eats regular meals. *Breakfast is especially important.*
- Encourage your child to eat healthy foods. Try snacks such as fruits, raw vegetables, yogurt, and cheese.
- Teach your child to wash their hands regularly and always before eating and after using the bathroom.
- Help your child to choose clean clothes suitable for school. Pants and sneakers are appropriate when they have Physical Education.
- Always make sure your child dresses appropriately for the weather. Children need to wear warm enough clothes to be comfortable for outdoor recess and their bus rides to and from school.
- Make sure your child wears a warm coat, hat, and gloves to school in the winter. They should also have snow pants and waterproof boots for wet and snowy conditions.

Onteora School District

HEALTH INFORMATION



Elementary School Nurses:

Heather Kight, RN-Woodstock

679-2316 Ext. 5140

Nara Scanlon, RN-Bennett

657-2354 Ext 4140

HEALTH OFFICE GOALS

Health problems make learning harder. The school nurse has the following goals to support your child's education:

- Maintain a healthy environment so children can learn effectively.
- Help the child maintain the highest level of health.
- Identify potential health problems and help families address them.
- Teach children healthy habits.

HOW WE HANDLE INJURIES AND ILLNESSES AT SCHOOL

The health office is only allowed to provide immediate First Aid and temporary care if a student is injured or becomes ill at school.

Under New York State Law, a nurse cannot diagnose a condition or provide more than first aid for an emergency.

- The school nurse will handle minor problems and send your child back to class if no further care is needed.
- The school will make every effort to reach a parent or guardian who cannot be reached, the school will call additional emergency numbers you have provided.
- Parents or guardians are responsible for transportation and further care. The school will help the parents or guardians plan transportation to home or medical facility.

- If your child is sent home early due to fever, vomiting or diarrhea, do not send them back to school until they are symptom free for 24hrs without fever-reducing medication.

WHAT YOU NEED TO TELL US

Who to Contact- all contact information must be kept up to date. Notify the office any time there are changes to the information.

The school sends home an annual form for the parent/guardian to update. This will tell the school how to reach you and who else to contact if you cannot be reached.

Information about your child's health

The school provides Health Forms for you to tell us about existing medical conditions your child might have and any special instructions for responding to problems that might occur.

Make sure you complete the Annual Health Summary and keep it up to date.

Please include the following:

- Chronic physical or medical conditions
- Medications your child takes
- Allergies to insect stings
- Food allergies such as milk, nuts, etc.
- History of any allergic reaction to medications.

ABSENCE FROM SCHOOL

If your child is absent from school, he or she must bring a written excuse that includes the

Student's name, the date(s) absent and the reason for the absence. The note must be signed by a parent/guardian. Please contact the school nurse with your child's absence and if your child has a contagious illness.

MEDICATIONS AT SCHOOL

Every effort should be made to avoid giving any medication in school. This includes homeopathic remedies, prescription, and non-prescription drugs (such as ibuprofen, cough drops, antacids, etc.).

If your child must take medications during school hours, you must do the following:

- Provide a **written request from your healthcare professional** that provides the name, the dose, and the frequency of the medication.
- Provide a **written request from the parent/guardian** to administer the medication
- Deliver the medication in the **original labeled container** to the health office.
- (The medication must be kept in the health office).
- The **provider and parent/guardian permission to administer medication forms** are available on our district wide website.

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in New York State. 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)²	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) ³		Not applicable		1 dose
Polio vaccine (IPV/OPV)⁴	3 doses		4 doses or 3 doses If the 3rd dose was received at 4 years or older	
Measles, Mumps and Rubella vaccine (MMR)⁵	1 dose		2 doses	
Hepatitis B vaccine⁶	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recomblvax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine⁷	1 dose		2 doses	
Meningococcal conjugate vaccine (MenACWY)⁸		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)⁹	1 to 4 doses			Not applicable
Pneumococcal Conjugate vaccine (PCV)¹⁰	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. 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 through 10: 10 years; minimum age for grades 11 and 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 2024-25, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 10; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 11 and 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 New York State 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, must 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 pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (pre-kindergarten 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 through 11: 10 years; minimum age for grade 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.
 - f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.
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 CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

For further information, contact:

New York State Department of Health
 Division of Vaccine Excellence
 Room 649, Corning Tower ESP
 Albany, NY 12237
 (518) 473-4437

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

New York State Department of Health/Division of Vaccine Excellence
 health.ny.gov/immunization

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

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 µg/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:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	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"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
Hearing 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					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> 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 NYSIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Onteora Central School District

Bennett 657-2354

Middle/High 657-2373

Woodstock 679-2316

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

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications, 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. I understand that the school nurse may be in touch with my health care provider to clarify medication orders.

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 _____ Stamp _____

Prescriber's Signature _____ Phone _____

Email _____

Return to:

School Nurse: _____ School: _____

School Address: _____

Phone: () _____ Fax: () _____ Email: _____

Onteora Central School District

Bennett 657-2354

Middle/High School 657-2373

Woodstock 679-2316

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 they 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: _____

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email:

ONTEORA CENTRAL SCHOOL DISTRICT
Health Office

Important Reminder

Dear Parents/Guardians:

All schools in the Onteora District are “Nut Aware” schools. This procedure has been implemented in order to provide a safe environment for students who are allergic to nuts (peanuts/tree nuts). An anaphylactic (severe) reaction can be devastating to the student or the students witnessing the reaction.

The follow steps are followed:

- The cafeteria does not offer peanut butter, only sun butter. Students may select other options available, turkey, tuna, ham and/or cheese, or sun butter & jelly sandwich. The snacks and cereal provided do not contain peanut products. Note: at the high school some snacks may contain nut products. All students and staff are reminded to observe signs and read labels.
- There are designated nut free tables in the Elementary school cafeterias, which are cleaned with different cleaning supplies. No nut products are allowed at the designated tables. There are no nut free tables at the Middle/High School. Nut (peanut/hazelnut) butter will be allowed to be eaten in the cafeteria, at tables away from the Nut Free table. We encourage minimizing sending in peanut butter or nut snacks. All children who eat nut products must wash their hands after eating. *If a nut/peanut allergic child touches an item after someone who has touched the same item with nut oils on their hands, a severe reaction could occur.*
- All common rooms are nut aware. If a student brings in an item with nuts they will follow the same procedure as the procedure in the cafeteria (see above). We recognize that nuts are a good and healthy snack for most children. We also know that students are in school only 6 hours each day and that there are other snacks that are just as healthy and will help others in our school community remain safe.
- Classroom teachers will determine if the classroom is nut free or will establish a nut free area, using the same precautions as the cafeteria.
- The school nurse and/or teacher will discuss food allergies with all classes in the school. The cafeteria staff will review the Nut Free procedures in the cafeteria at the beginning of the school year and throughout the year as needed.
- Staff members will be trained in the use of Epi-Pen if applicable for specific students.
- Parents should check with the school nurse and/or classroom teacher before bringing in snacks for the classroom for any allergies.
- Research and materials on this condition, and how other schools approach the same situation, are continually reviewed.

It is our responsibility to minimize the risk for all our students to the greatest extent possible. No child should have to be afraid to come to school for fear that he/she will have a potentially life threatening reaction. These minor changes reduce the risk significantly for all of our children.

Feel free to contact your child’s school principal or school nurse with any concerns you may have. We will work with you to help find a solution to your concerns. Thank you for assisting us in keeping all children safe.

**HEALTH SUMMARY
MUST BE RENEWED ANNUALLY**

Student Name: _____ **Phone:** _____ **Birth date:** _____ **Grade:** _____

Current Address: _____

Please note: Student health concerns, including, but not limited to: food allergies/bee sting allergies, diabetes, breathing problems, seizures or any health issue that could interfere with your child’s learning will be shared with classroom teachers and appropriate staff who “Need To Know” unless you specify otherwise by notifying the school nurse.

Current Physician/Health Care Provider: _____ **Phone** _____

Date of last visit to physician: _____ **Reason:** _____

Has this child had any of the following during the last year? (If yes, please explain in space provided)

- ◆ Severe injuries requiring medical attention _____
- ◆ Serious illness or operations _____
- ◆ Visits to the emergency room for treatment _____
- ◆ Changes in wearing glasses or contact lenses _____
- ◆ New allergies diagnosed _____
- ◆ Chronic disease diagnosed _____
- ◆ Asthma or breathing problems _____
- ◆ Seizures/Convulsions _____
- ◆ COVID-19 _____

Is this child receiving any prescribed medication? (If so, please list)

Has this child received any immunizations since last year? (If so, please list with dates and provider)

Are there any family changes or difficulties, which may influence school performance or behavior?

Are there any other services or agencies involved with your child or family? (e.g. counselors, therapists, social service agencies. If so, please list)

Is there any other information about the health and well being of this child which is important for a successful school experience this year? (If so, please describe)

Completed by: _____ **Relationship to Student:** _____ **Date:** _____
Print name

Signature _____

ONTEORA CENTRAL SCHOOL DISTRICT

High School/Middle School – (845)657-2373, Bennett Elementary - 657-2354, Phoenicia Elementary - 688-5580, Woodstock Elementary 679-2316

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Sex: Male Female Will this be your child's first visit to a dentist? Yes No
Month Day Year

School: Name Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

- Yes No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes No **Untreated Caries** – Does this child have an open cavity? [At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

