

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)

**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/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 ≥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

Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code\*

Additional Information Attached

\*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision</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"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
<b>Hearing</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> (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.					
<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 NYSIS		
<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>					



## Onteora Central School District

Middle & High School  
4166 State Route 28  
P.O. Box 300  
Boiceville, NY 12412

Tel. (845)657-2373

Fax (845)657-8430

Dear Parent/Guardian:


If it becomes necessary for a student to take any form of medication at school, the following steps must be followed:


1. A written order from the physician must be obtained which includes the student's name, medication, dosage and time to be given at school and route of administration.
2. Permission must be given in writing by you, the parent/guardian, in order for the medication to be given at school.
3. The medication must be delivered to the school in its original pharmacy container, properly identified with the student's name, date prescribed, name of medication, dosage and instructions for administering.
4. The medication must be kept in the health office in a locked cabinet.
5. At no time should a student have prescription or non-prescription medication/drugs on them (i.e. Tylenol, aspirin, Advil, alcohol-based hand sanitizer, etc.).

School personnel may not administer any medication including over-the-counter medications, unless the above conditions have been met.

Some conditions may necessitate that a child carry and self-administer his/her medication. Examples would be an inhaler for severe asthma or an Epi-pen for serious bee sting allergies. The school should have knowledge of these medications prior to a student bringing them into school. ADHD medication, anti-seizure drugs and antibiotics are examples of non-emergency medications, and must be administered through the nurse's office. If you believe your child has potential emergency health needs, please consult with the school nurse to develop an emergency care plan. Students may not possess, consume, or distribute any type of medication without the approval of the school's administration and/or health office.

These policies and procedures are necessary to ensure the health and safety of the entire student body. We appreciate your cooperation and compliance.

  
Lance Edelman  
High School Principal

  
James DiDonna  
Middle School Principal

Onteora Central School District

Bennett 657-2354

Middle/High School 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: Karen Hansen, RN School: Onteora Middle School

School Address: PO BOX 300, Rt 28, Boiceville, NY 12412

Phone: (845) 657-2373 ext. 2240 Fax: (845) 657-8430 Email: khansen@onteora.k12.ny.us

# 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: Karen Hansen, RN	School: Onteora Middle School
Phone #: (845)657-2373 ext 2240	Fax: (845)657-8430 Email: khansen@onteora.k12.ny.us

**HEALTH SUMMARY  
MUST BE RENEWED ANNUALLY**

**Student Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

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**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)**

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

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

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

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**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)**

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**Completed by:** \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Print name**

**Signature** \_\_\_\_\_

**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.



# 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.

