Pine Plains Central School District
2829 Church Street
Pine Plains, NY 12567

Cold Spring Early Learning Center
358 Homan Road
Stanfordville, NY 12581
School Nurse, J. Heath, RN
j.heath@ppcsd.org
(845) 868-7451 ext. 2239; (845) 868-1105 (f)

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Dear Parent/Guardian:

We hope this letter finds you all well. In preparation of the next school year, we are working on making the Health/Medical paperwork process as simple as possible. Several different forms will be attached to this email. Not all forms will need to be filled out for every student. Please look at the following form descriptions to see which ones apply to your child. All forms that are *italic/underlined* can also be found under the Health Services section of our PPCSD website. Click on *Departments → Health Services →Medical Documents for Students.* We will be updating any changes from NYS here as well. Hard copies of these forms are available upon request.

Over the Counter Medication: **Applicable to all students.**
The *Medication/Treatment Cover Letter* and the *OTC/Treatment Form* are attached. We strongly encourage this form to be filled out for all students so that we may be able to administer over-the-counter medications should your child need something during the school day. This form must be signed both by a **parent and doctor.** ***We will NOT be able to administer any medications without it***.

Prescription Medication/Independent: Applies only to those students that require administration of prescription medication in school and during school activities. The *Prescription Medication Form* should be filled out for all daily medications, inhalers, epi-pens, diabetic medication, etc... This form also designates your child's level of medication delivery dependency. Please make sure the proper box is checked. If your child is deemed "Supervised" it will allow another designated adult to assist your child in the absence of the School Nurse, i.e. field trips, before or after school activities.

Student Health Examination Form/Dental Certificate: Applies to a variety of grade levels. The current *Student Health Examination Form Cover Letter* and the *Required New York State School Health Examination Form* are attached. **NYS Education Law requires all new entrants and students in grades PreK or K, 1, 3, 5, 7, 9, and 11 have a current health examination on file.** In addition, while not required, NYS requests that a *Dental Health Certificate* which states your child has been seen by a dentist or dental hygienist be submitted at this time.

Action Plans: Applies only to those that have a known health condition or concern. The *NYSDOH Asthma Action Plan* and *FARE Food Allergy and Anaphylaxis Emergency Care Plan* should be filled out by your child's healthcare provider if applicable. Any child with a history of: Seizure Disorder, Cardiac Condition, Diabetes etc. should have their MD complete an Individualized Health Care Plan. Any new health concerns that have occurred over the summer should be reported to the health office at the start of the upcoming school year.

Required Immunization Notice: **Applicable to all Students**
As per the NYSED: The Bureau of Immunization of the New York State Department of Health has legal authority to ensure that schools throughout the state comply with Section 2164(7)(a) of the Public Health Law related to immunization requirements for school entry. Public Health Law Section 2164(7)(a) requires that: No principal, teacher, owner or person in charge of a school shall permit any child to be admitted to such school, or to attend such school, in excess of **fourteen days**, without the certificate provided for in subdivision five of this section or some other acceptable evidence of the child's immunization against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, hepatitis B, tetanus and pertussis and, where applicable, Haemophilus influenzae type b (Hib), meningococcal disease and pneumococcal disease; provided, however, such fourteen day period may be extended to not more than thirty days for an individual student by the appropriate principal, teacher, owner or other person in charge where such student is transferring from out-of-state or

from another country and can show a good faith effort to get the necessary certification or other evidence of immunization. **For the 2024-25 School Year: Documentation must be received no later than Wednesday, September 18, 2024. If not received by that date, your child will not be permitted to attend school.**

Please send proof of immunization to the school nurse where your child will be attending. Documentation of immunizations must be signed or stamped by a physician. Attaching the *2024-25 NYS Immunization Requirements* chart for reference.

Please have appropriate forms completed by your child's healthcare provider for the upcoming school year and remember to sign all documents. Return all forms upon completion to your child's respective building or email them to the proper email address above. Again, all medications must be delivered to the school by an adult in a pharmacy labeled container or in the original packaging.

Feel free to contact us with any questions. Wishing you all a happy, healthy summer!

Sincerely,

Pine Plains Central School Nurses

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Estimados padres y tutores legales:

Esperamos que esta carta te encuentre bien. En preparación para el próximo año escolar, estamos trabajando para que el proceso de trámites médicos/sanitarios sea lo más sencillo posible. Se adjuntarán varios formularios diferentes a este correo electrónico. No se necesitarán rellenar todos los formularios para cada estudiante. Por favor Mire las siguientes descripciones de los formularios para ver cuáles se aplican a su hijo. Todos los formularios que están en *cursiva/subrayados* también se pueden encontrar en la sección de Servicios de Salud de nuestro sitio web de PPCSD. Haga clic en *Departamentos → Servicios de Salud → Documentos médicos para estudiantes*. Estaremos actualizando cualquier cambio de NYS aquí también. Copias impresas de estos formularios están disponibles a pedido.

Medicamentos sin receta: **Pertinente a todos los estudiantes.**
Se adjuntan *la carta de presentación del medicamento/tratamiento* y *el formulario de tratamiento/OTC*. Recomendamos encarecidamente que todos los estudiantes completen este formulario para que podamos administrar medicamentos de venta libre en caso de que su hijo necesite algo durante el día escolar. Este formulario debe estar firmado por uno de los padres y el médico. ***NO podremos administrar ningún medicamento sin este formulario necesario***.

Medicamentos recetados/Independientes: Estos medicamentos solamente se aplica para aquellos estudiantes que requieran la administración de medicamentos recetados en la escuela y durante las actividades escolares. El *Formulario de Medicamentos* Recetados debe ser rellenado para todos los medicamentos diarios, inhaladores, epi-pens, medicamentos para los que son diabéticos, etc.… Este formulario también indica el nivel de dependencia de entrega de medicamentos de su hijo. Por favor, asegúrese de que la casilla adecuada esté marcada. Si su hijo se considera "supervisado", permitirá que otro adulto designado lo ayude en ausencia de la enfermera escolar, es decir, excursiones, actividades antes o después de la escuela.

Formulario de examen de salud del estudiante/Certificado dental: Este formulario se aplica a una variedad de niveles de grado. Se adjuntan *la carta de presentación del formulario de examen de salud del estudiante actual* y *el formulario de examen de salud escolar obligatorio del estado de Nueva York*. **La Ley de Educación del Estado de Nueva York requiere que todos los nuevos ingresos y los estudiantes en los grados PreK o K, 1, 3, 5, 7, 9 y 11 tengan un examen de salud actualizado en el archivo.** Además, aunque no es obligatorio, el Estado de Nueva York solicita que se presente en este momento un Certificado de salud dental que indique que su hijo ha sido atendido por un dentista o higienista dental.

Plan de acción: Se aplica solo a aquellos que tengan una condición o preocupación de salud conocida. *El plan de acción contra el asma del NYSDOH* y *el plan de atención de emergencia para alergias alimentarias y anafilaxia de FARE* deben ser completados por el proveedor de atención médica de su hijo, si corresponde. Cualquier niño con antecedentes de: trastorno convulsivo, afección cardíaca, diabetes, etc. debe hacer que su médico complete un plan de atención médica individualizado. Cualquier nuevo problema de salud que haya ocurrido durante el verano debe informarse a la oficina de salud al comienzo del próximo año escolar.

Aviso de Vacunas Requeridas: Aplicable a todos los Estudiantes
Según el NYSED: La Oficina de Vacunación del Departamento de Salud del Estado de Nueva York tiene la autoridad legal para garantizar que las escuelas de todo el estado cumplan con la Sección 2164(7)(a) de la Ley de Salud Pública relacionada con los requisitos de vacunación para ingresar a la escuela. La Sección 2164(7)(a) de la Ley de Salud Pública

requiere que: Ningún director, maestro, propietario o persona a cargo de una escuela permitirá que ningún niño sea admitido en dicha escuela, o que asista a dicha escuela, por más de catorce días, sin el certificado previsto en la subdivisión cinco de esta sección o alguna otra evidencia aceptable de la inmunización del niño contra la poliomielitis, paperas, sarampión, difteria, rubéola, varicela, hepatitis B, tétanos y tos ferina y, en su caso, Haemophilus influenzae tipo b (Hib), enfermedad meningocócica y enfermedad neumocócica; siempre que, sin embargo, dicho período de catorce días pueda extenderse a no más de treinta días para un estudiante individual por parte del director, maestro, propietario u otra persona a cargo correspondiente cuando dicho estudiante se transfiera desde otro estado o desde otro país y puede mostrar un esfuerzo de buena fe para obtener la certificación necesaria u otra evidencia de inmunización. **Para el año escolar 2024-25: la documentación debe recibirse a más tardar el miércoles 18 de septiembre de 2024. Si no se recibe antes de esa fecha, a su hijo no se le permitirá asistir a la escuela.**

Por favor envíele una prueba de vacunación a la enfermera de la escuela a la que asistirá su hijo. La documentación de las vacunas debe estar firmada o sellada por un médico. *Adjunto la tabla de requisitos de vacunación del estado de Nueva York de 2024-25* como referencia.

Haga que el proveedor de atención médica de su hijo complete los formularios apropiados para el próximo año escolar y recuerde firmar todos los documentos. Devuelva todos los formularios una vez completados al edificio respectivo de su hijo o envíelos por correo electrónico a la dirección de correo electrónico adecuada arriba. Nuevamente, todos los medicamentos deben ser entregados a la escuela por un adulto en un recipiente con etiqueta de farmacia o en el empaque original.

No dude en ponerse en contacto con nosotras con cualquier pregunta. ¡Les deseo un verano feliz y saludable!

Sinceramente,

Las enfermeras del Distrito Escolar de Pine Plains

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RE: Medication/Treatment Cover Letter

Dear Parent/Guardian:

The Health Office will be stocking these Over-the-Counter (OTC) medications: Acetaminophen (Tylenol), Antacid (Tums), Calamine, Benadryl, Antibiotic Ointment, Hydrocortisone Ointment, Aloe Vera Gel and Solarcaine. If these medications are ordered and authorized, you do not have to bring them to school for your child.

We have included a Doctors order form listing all Over-the-Counter medications in this packet. If you would like for your child to receive the above listed Over-the-Counter medications while at school, please have your doctor fill out the order form enclosed in this packet.

It is also acceptable if your doctor fills out his/her own form from their office. Please make sure this form states the name of medication, dosage, length, time and reason for administration.

All other medications, **OTC and Prescription**, will need a doctor's order and parental authorization on file in order to be given at school. This form is enclosed as well. **The medication must be in its original package or prescription container with professional label and must be provided by you and delivered to the school by an adult.**

In the rare instance when the school nurse (or nurse substitute) is not available to administer medication, **medication will not be given unless your child is considered to be *Supervised* or *Independent*** (**SEE ATTACHED FORM**). This policy also applies to field trips where the school nurse will not be in attendance. If your child is not ***Supervised*** (self-directed) you may come to the school/field trip to administer your child's medication, or you may delegate this task to an adult not employed by the school district.

Again, all forms require written parental permission. Your child cannot receive medication without both of these authorizations on file in the Health Office.

All medication orders and parental authorizations must be renewed yearly.

Please feel free to give us a call if you have any questions.

Thank you,

School Nurses
Pine Plains Central School District

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RE: OTC/Treatment Form

*If you would like your child to have access to anything noted below New York State requires that **both** a physician and parent sign this form.*

Student Name_____ Grade_____
(Please Print) Last First

Please administer, as needed, the following over the counter medications throughout the school year to the above mentioned student as directed below:

Tylenol for headache, pain, or discomfort due to a low-grade fever
Tums for an upset stomach
Calamine lotion or Hydrocortisone cream for itchy rash
Aloe Vera Gel for minor burns, insect bites, skin irritations
Benadryl for allergic reactions
Solarcaine for sunburn
Burn-Jel for burns
Antibiotic ointment for lacerations, tick bites or abrasions
Sting relief swab for bee stings and insect bites
_____
_____

- Please cross off the list anything you are not comfortable with and add anything else you feel your child may need (The above list is stocked by each school. **Any other medication will have to be provided by you in the original container and brought to school by an adult**).
- Generic forms may be used.
- Unless otherwise noted, all of the above will be administered as per label instructions.

Physician's Signature_____

Physician's Phone Number _____Date_____

I request that the Health Office personnel administer the above medication to my child as prescribed by their physician.

Parent Signature_____

Parent Name (please print)_____

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RE: Prescription Medication Form

PART 1 (to be completed by physician):

Student's Name: _____ DOB: _____

Diagnosis: _____Duration of Treatment: _____

MEDICATION	DOSAGE	ROUTE OF ADMINISTRATION	FREQUENCY

Possible Side Effects: _____

PLEASE CHECK ONE:

- ☐ I deem this child **NURSE DEPENDENT** and state that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, physician or parent.
- ☐ I deem this child **SUPERVISED:** in the absence of the school nurse, another designated adult may assist child.
- ☐ I deem this child **INDEPENDENT:** student has been instructed in the proper use of the above listed medication(s) and is permitted to self-carry and self-administer**.** It is my professional opinion that this student is responsible**.**

Physician Signature: _____ Date: _____

PART 2 (to be completed by parent or guardian):

I request that my child _____receive the medication as prescribed above by our physician. If my child is **INDEPENDENT,** I request that he/she be permitted to carry the above prescribed medication(s) on his/her person or to keep the above prescribed medication(s) in his/her locker and **SELF-MEDICATE**, as I consider him/her responsible. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, *the privilege* of carrying his/her medication will be rescinded. If my child is **SUPERVISED**: I will allow another designated individual to assist my child with medication administration in the absence of the school nurse.

Parent or Guardian Signature: _____ Date: _____

MEDICATION MUST BE DELIVERED TO SCHOOL BY AN ADULT IN AN ORIGINAL PHARMACY LABELED CONTAINER.

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RE: Student Health Examination Form Cover Letter

Dear Parent/Guardian:

All children entering the following grades in the upcoming school year are required, by New York State Education Law Article 19 and Regulations of the Commissioner of Education (8 NYCRR), to have a physical, not more than 12 months prior to the commencement of the school year in which the exam is required.

Physicals are **required** for students:

- Entering the school district for the first time, and in grades **pre-K or K, 1, 3, 5, 7, 9, and 11**; and at any grade level as recommended by school administration, in their discretion to promote the educational interests of the student
- In order to participate in strenuous physical activity, such as interscholastic athletics
- In order to obtain an employment certificate
- When conducting an individual evaluation or reevaluation of a student suspected of having a disability or a student with a disability

If you would prefer to have your child's exam done by his/her own doctor, it must:

- Have been done no more than 12 months prior to the start of the school year.
- Be completed and signed by the examining New York State licensed physician, physician assistant or nurse practitioner and submitted on the approved NYSED form.
- Returned to the School Health Office within thirty (30) days of your child's first day of school.

If the completed form is not on file within thirty (30) days, the school will contact you. If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date. If not, the exam will be done at school when the rest of your child's class is scheduled. Please note that physicals are good for one calendar year.

IMPORTANT

As of 1/31/2021 we can no longer accept Health Appraisals that are not on the ***Required New York State School Health Examination Form*** or the required health record equivalent. Both the Health Examination Form and the instructions for your Health Care Provider (HCP) are available upon request in the Health Office and are on the PPCSD website. *Click on Departments → Health Services → Medical Documents for Students* and then select the form needed on the right.

You will be notified if your student's health exam is not provided on the correct form. If the proper form is not subsequently received (after attempts are made to get provider compliance), the health examination will need to be repeated at the school by the school district's Medical Director. If your provider refuses to use the *Required New York State School Health Examination Form* you may contact your health insurance company.

Please feel free to contact us if you have any questions.

Sincerely,
Pine Plains Central School Nurses

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

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

☐ **System Review Within Normal Limits**

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

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

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

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

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

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

Notes

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

Notes

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

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

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

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

If Restrictions Apply – Complete the information below

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

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

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

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

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

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

MEDICATIONS

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

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

HEALTHCARE PROVIDER

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

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

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, Pre-K or K, 1, 3, 5, 7, 9, & 11. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist'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 ½ 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):_____

II. 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.

Instructions for Completion of the New York State School Health Examination EHR Compatible Form

In lieu of using the required NYS Health Examination Form, providers may choose to use the approved electronic health record (EHR) compatible form. However, in order to meet all NYS regulatory requirements these directions must be used with the EHR compatible form. The EHR compatible form is to be completed in its entirety (indicate if suggested tests/screenings are not done, or not applicable) by the private provider or school medical director. Education Law requires a physical exam for new entrants and students in grades pre-K or K, 1, 3, 5, 7, 9, and 11; annually for inter-scholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-school special education (CPSE). The date of examination must be noted on the form and be not more than 12 months prior to the start of the school year.

Health History

1. Chronic medical conditions should be listed in patient's problem list. ICD-10 codes should accompany diagnoses ONLY for patients who have Medicaid and have an Individualized Education Plan (IEP) for special education in school and receive related services (i.e. nursing, social worker/psychologist, PT/OT/ST, or special transportation). Alternatively, an order for services with the ICD10 codes included can be submitted separately.
2. Asthma, seizure disorders, life threatening allergies and diabetes must be included if diagnosed, and each require a separately attached care plan:

    a. Allergies - life threatening allergy care plans should specify what the patient is allergic to. See AAAI Sample Anaphylaxis Emergency Action Plan;
    b. Asthma - Asthma Action Plans should include medication orders along with directives. See NYSDOH Asthma Action Plan;
    c. Seizure disorders care plans should include date of last known seizure. See NYSCSH Seizure ECP with Medication Information ; and
    d. Diabetes- requires a Diabetes Medical Management Plan (DMMP) specifying the type of diabetes. See NYSDOH Diabetes Medical Management Plan;

3. Consider screening for T2DM if BMI% >85% and child has 2 or more risk factors: Family history of T2DM, ethnicity, symptoms of insulin resistance, history of gestational diabetes in the mother, and/or pre-diabetes.
4. Include hyperlipidemia and hypertension if diagnosed.
5. Include mention of unpaired eye, kidney or testicle if relevant.
6. Include mental health diagnoses where permitted by patient/family.
7. Under allergies, list all allergies including medication, food, insects, latex, and other environmental allergens.
8. Attach medication administration forms for medication which will be administered in school.
9. Include problems relevant to the child's needs at school if not included in the problem list .
10. Height, weight, and BMI must be provided including percentile for each, as well as marking appropriate BMI category. Those include <5th, 5th-49th, 50th-84th, 85th-94th, 95th-98th, 99th and greater.
11. Pulse and respiratory rate are to be documented for students with diagnosed respiratory or cardiac conditions whose baseline rates are outside the normal range for age.

Laboratory and Diagnostic Testing

1. Tuberculosis screening, if indicated and performed, should specify type of testing (PPD or Interferon-gamma release assay), result, and test date.
2. Results of most recent prior lead level testing is required for students in PreK and K if available. If no test results reported the family will be given educational information about lead poisoning by school personnel.
3. Sickle cell screening is optional based upon discretion of provider.
4. Screening for vision and hearing in grades PreK or K, 1, 3, 5, 7, and 11, and for scoliosis in grades 5 and 7 for girls, grade 9 for boys that is not done or reported on the school form will be performed by the school.
    - Vision screening should include the results of distance acuity testing in each eye (pass is 20/30 or better), an assessment of near vision acuity (pass is 20/40 or better). Color vision (pass/fail) is required if student is attending a new school. See NYSED Vision Screening Guidelines for Schools .
    - Hearing screening should be performed at 20 dB and pass or fail noted for each frequency (500Hz, 1000Hz, 2000Hz, 4000Hz); for children ≥11 years of age (grades 7 & 11) should also be screened for high frequency hearing loss by testing at 6000Hz and 8000Hz. See NYSED Hearing Screening Guidelines for Schools .

Physical Examination/ Assessment

1. A complete physical exam must include the following systems: HEENT, Dental, Neck, Lymph nodes, Lungs, Abdomen, Back/Spine including screening for scoliosis (see above grade levels), Genitourinary, Extremities, Skin, Neurological, Cardiovascular, Speech/Language, Social-Emotional, and Musculoskeletal. Abnormal findings on review of systems and physical exam should be noted.

Tanner Staging (1-5) is required ONLY for any student in Grades 7 or 8 to play sports at a high school level or Grades 9-12 to play middle school level sports

Assessment and Recommendations

1. State "has no restrictions" if applicable. Please note any restrictions on physical activity including participation in physical education, sports, playground and work. Include applicable limitations on participation in sports by level of contact:
    a. Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling
    b. Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball
    c. Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field

2. List any accommodations required for participation, including but not limited to: Brace/Orthotic, Insulin pump/sensor, Protective equipment, Colostomy appliance, Medical/Prosthetic device, Sport safety goggles, Hearing aids, Pacemaker/Defibrillator, etc. Specific approval and associated documentation may be required if use of device will occur during athletic competitions, please check with athletic governing body for more information.
3. Chronic medications needed **at school** should be listed and include- medication strength/concentration, formulation, dose, frequency, and timing- or indicate separate order attached.
4. Providers may attach an immunization form or refer to NYSIIS registry if record available and complete.
5. Referrals, such as those for abnormalities on vision or hearing screening should be noted.
6. Please include any additional information that may be useful to the school that is not otherwise solicited.

Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s):_____

☐ _____

Take _____ puff(s) or _____ tablet(s) _____ daily.

☐ For asthma with exercise, ADD: _____,

_____ puffs with spacer _____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

You have ANY of these:
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ _____ inhaler _____ mcg

Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml

Take a _____ nebulizer treatment every _____ hours, *if needed*.

☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

You have ANY of these:
- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ _____ inhaler _____ mcg

Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml

Take a _____ nebulizer treatment every _____ hours, *if needed*.

☐ Other _____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____ – _____ .

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

COPY FOR PATIENT

FARE Food Allergy Research & 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:_____

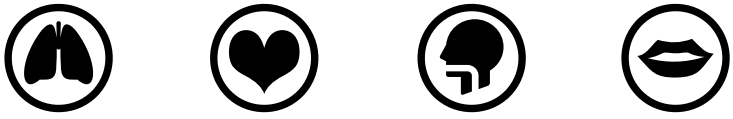
THEREFORE:

☐ 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

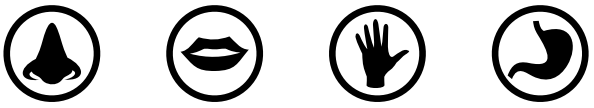
OTHER
Feeling something bad is about to happen, anxiety, confusion

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:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. 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

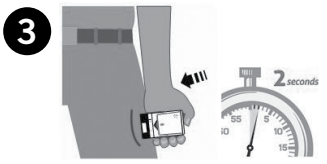
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

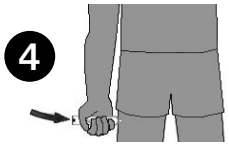
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



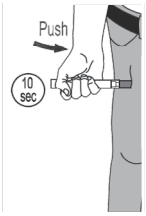
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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 ADRENACLICK®), 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 SYMJEPI™ (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 SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI 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: _____

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

2024-25 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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 vaccine[6]	**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[7]	**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**		

NEW YORK STATE | Department of Health

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:

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