MAMARONECK UNION FREE
SCHOOL DISTRICT
Mamaroneck, NY 10543

Pre - Kindergarten

Dear Parents/ Guardians of Pre - Kindergarten Students,

Please complete the following forms in the enclosed packet:

1. Physical Examination Certificate: to be completed by a New York State physician/ practitioner after having a physical examination.

By law, all new students and those entering grades pre-kindergarten, kindergarten, first, third, fifth, seventh, ninth and eleventh must have a NYS physical examination. Completed forms signed, stamped and dated within the last 12 months are acceptable.

2. Vaccination Administration Form: to be completed by your child's physician/ practitioner.

3. Tuberculin Screening Form: to be completed by your child's physician/practitioner.

4. Body Mass Index Form (BMI): (form not included in packet)

The School Nurse must submit a BMI and Weight Status Category report on students needing physical exams. Should you choose NOT to want your child's anonymous data reported to the State, please go to our website and print out the BMI Refusal Form, sign it and return it to your School Nurse as soon as possible.

5. Child Health History Information Form: to be completed by the parent/ guardian.

The information on this form helps ascertain the current health status of your child. This form is to be completed annually.

6. Dental Examination Certificate: to be completed by your child's dentist.

New York State requires public schools to request a dental health certificate for students at the time of school entry and in grades pre-kindergarten, kindergarten, first, third, fifth, seventh, ninth and eleventh.

7. Medication Permission Sheet: to be completed and signed by your child's physician/ practitioner and signed by a parent/ guardian, only if your child will be taking any medication while he or she is at school during the school day.

This form is NOT included in your packet. If needed, please pick one up at the Health Office or print it from the school website.

No student may bring in or take any medication in school (including inhalers) without a completed Medication Permission Sheet as well as a pharmacy labeled container for the medicine. This includes ALL medicines such as Tylenol or Motrin etc. All medications are kept locked in the nurse's office.

If your child has asthma, it is recommended to keep an extra inhaler at the nurse's office.

8. Lead Screening Notice: to be completed by your child's physician/practitioner. Review the attached Lead Screening information

You may upload your Health documents into Operoo or bring them directly to your child's school. Make sure to keep a copy for yourself.

PLEASE DO NOT MAIL FORMS DURING THE SUMMER MONTHS.

NEW STUDENTS MAY NOT BEGIN SCHOOL WITHOUT BEING MEDICALLY CLEARED BY THE BUILDING NURSE.

If you have any questions, please call or stop by the Health Office. Thank you for your cooperation.

Sincerely,

Central School Nurse - 914-220-3410
Chatsworth School Nurse – 914-220-3510
Mamaroneck Ave School Nurse – 914-220-3610
Mamaroneck Ave School Nurse - 914–220-3618
Murray School Nurse – 914-220-3710

ALL FORMS ARE AVAILABLE ON LINE AT
HYPERLINK
"HTTP://WWW.MAMKSCHOOLS.ORG"
WWW.MAMKSCHOOLS.ORG- COMMUNITY- HEALTH SERVICES-RESOURCES - REGISTRATION HEALTH PACKET

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: ☐ 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:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

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

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** ☐ 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 Dominic 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*:** (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

☐ 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.

MAMARONECK UNION FREE SCHOOL DISTRICT
VACCINATION ADMINISTRATION RECORD

Please return this report to your **School Nurse** as soon as your child's vaccinations have been given and/or updated. Failure to provide acceptable evidence of immunizations within fourteen days of entry may lead to exclusion from school. This period may be extended up to thirty days for those transferring from out of state or abroad. Vaccines must follow the Advisory Committee for Immunization (ACIP) guidelines.

This form should be completed and/or updated annually. Please see the list of immunization requirements below:

NAME: _____ **DATE:** _____

DOB: _____**GRADE:** _____**TEACHER/COUNSELOR** _____

School: ❍ CEN ❍ CHAT ❍ MAS ❍ MUR ❍ HMX ❍ HS ❍ Other: _____

Immunization Requirements:

As required by NY State Dept. of Education, Health Care Provider verification of the following is needed for school attendance:

- **DTaP : three - five (3-5) doses** of diphtheria and tetanus toxoid-containing vaccine and acellular pertussis vaccine
- **Tdap : one (1)dose -** students 11 years of age or older entering grade 6 through 12 are required to have one dose of Tdap
- **IPV : three – four (3-4) doses** of polio vaccine
- **MMR : two (2) doses** of live measles, mumps and rubella vaccine (K-12)
- **Hepatitis B: three (3) doses** of Hepatitis B vaccine at intervals recommended by the ACIP
- **VARICELLA: – two (2) doses** of Varicella (chicken Pox) entering kindergarten through Grade12
- **MENINGOCOCCAL: one (1) dose** entering Grade 7 through 11, one-**two (1-2) doses** at age 16 and entering Grade 12

In addition, for pre-kindergartners:

- **Hib** Haemophilus influenzae type b vaccine**:** 1-4 doses
- **PCV** Pneumococcal conjugate (**PCV**) 1-4 doses (age appropriate)
- **MMR & Varicella :** one (1)dose

VACCINATION ADMINISTRATION RECORD
TO BE COMPLETED & SIGNED BY THE HEALTH CARE PROVIDER

VACCINE DATE GIVEN:

DTaP 1 _____ DTaP 3 _____

DTaP 2 _____ DTaP 4 _____

DTaP 5 _____ **OR…**

DT 1 _____ **OR** Td 1 _____

DT 2 _____ **OR** Td 2 _____

DT 3 _____ **OR** Td 3 _____

Tdap _____

IPV 1 _____ IPV 3 _____

IPV 2 _____ IPV 4 _____

VARICELLA 1 _____

VARICELLA 2 _____

MMR 1 _____

MMR 2 _____

TST (LAST) MANTOUX _____ RESULT _____❖

BCG _____

❖ If Positive TST, Chest x-ray needed:
Date of CXR: _____ Results: _____

VACCINE DATE GIVEN:

HEP B 1 _____

HEP B 2 _____

HEP B 3 _____

OR (Adult formulation 2 dose series, ages 11 – 15 yrs)

HEP B 1 (1.0 ML) _____

HEP B 2 (1.0 ML) _____

HIB 1 _____

HIB 2 _____

HIB 3 _____

HIB 4 _____

PNEUMOCOCCAL VACCINE

1 _____ 2 _____ 3 _____ 4 _____

MENINGOCOCCAL VACCINE _____

MENINGOCOCCAL VACCINE _____

HEP A 1 _____ HEP A 2 _____

HUMAN PAPILLOMAVIRUS VACCINE (HPV)

1 _____ 2 _____ 3 _____

COVID _____

Other _____

OFFICE STAMP NECESSARY HERE ⬇

Healthcare Provider

NAME (Print) _____ SIGNATURE: _____

ADDRESS: _____ TELEPHONE #: _____

CITY/STATE/ZIP: _____ DATE**:** _____

MAMARONECK UNION FREE SCHOOL DISTRICT

HEALTH OFFICE

Tuberculosis Screening/Clearance

Student's Name _____

Mamaroneck Schools require TB risk assessment for all incoming new students.

Students with **NO RISK FACTORS** do not require further testing.

_____ This student has no TB risk factors

MD SIGNATURE HERE_____

DATE_____ STAMP_____

Students with Risk Factors require TB testing:

_____ History of TB exposure

_____ Immigration from high incidence countries (Asia, Africa, Eastern Europe, Central & South America)

_____ Lodging with local residents, families in high incidence countries during travel

_____ Household contact with family members from high incidence countries

_____ Exposure to HIV infected, homeless, drug using or incarcerated individuals

_____ **TUBERCULIN SKIN TEST (TST)**

Date Placed_____ Date Read_____

mm of Induration_____

_____ Chest X-ray results

MD SIGNATURE HERE _____

DATE_____ STAMP_____

Please see over for helpful information

These countries have LOW RATES OF TB. (2014 WHO)

Australia, Austria, Bahamas, Belgium, Canada, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Luxembourg, Malta, Netherlands, New Zealand, Norway, Puerto Rico, Slovakia, Slovenia, Sweden, Switzerland, United Arab Emirates, United States of America. West Bank and Gaza Strip.

All other countries not listed have high rates of TB exposure (and require testing)

If Tuberculin Test or IGRA is positive, now or previously, the following are required:

1. **Date of Positive TST or IGRA** **Date**: _____/ _____/ _____

2. **Chest X-ray: (Please attach copy of report)** **Date**: _____/ _____/ _____

   _____ **Normal**

   _____ **Abnormal** _____
   (Describe)

3. **Clinical Evaluation:**
   _____ **Normal**

   _____ **Abnormal** _____
   (Describe)

4. **Treatment:**
   _____ **No** _____
   (Please explain)

   _____ **Yes** _____
   (Drug, Dose, Frequency, Dates)

Additional review of history, if indicated:

- BCG Vaccine _____date
- Previous POS TST_____ date
- Previous treatment_____date

Any other comments _____

Thank you.

Mamaroneck Union Free School District

STUDENT MEDICAL HISTORY INFORMATION

(To be completed by Parent or Guardian at the beginning of each school year)

Your student's learning depends upon good health. To assist in providing health services at school, please complete the following form. Information is confidential and may be shared with teaching staff as needed. **Return this form to the school nurse as soon as possible.** Thank you.

Student's Name: (Please print) _____ **Date of birth:** _____ **Male☐ Female☐**

Grade:_____ **Teacher/Counselor**: _____

School: ☐ Central ☐Chatsworth ☐Mamaroneck Avenue ☐Murray
☐Hommocks ☐High School ☐ Other

Resides with Parent/Guardian Name(s): _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Doctor's name: _____ Date of last physical: _____
Dentist's name: _____ Date of last visit: _____

Is the student under an orthodontist's care? ☐No ☐Yes **Doctor's Name**_____

Birth history: Any complications or problems during pregnancy and/or delivery? ☐No ☐Yes
Please describe: _____
Full term birth? ☐No ☐Yes If no, how premature was the child? ____(weeks). Birth weight: _____lbs. _____oz.

Has the student ever had:	YES	Date:		YES	Date:
Chicken Pox	☐	_____	Meningitis	☐	_____
Encephalitis	☐	_____	Rheumatic Fever	☐	_____
Lyme disease	☐	_____	Positive TB test	☐	_____
Bleeding tendency	☐	_____	Pneumonia	☐	_____
High Blood Pressure	☐	_____	Kidney disease	☐	_____

Any complications from above illnesses? (please explain) _____

Does the student have or had a history of the following?

• Allergies? Yes ☐
To drugs, food, insects, pollen? Please list:_____
Has the allergy required emergency action in the past? No☐ Yes☐
What happens to the student? _____

• Asthma? Yes ☐
Triggered by: _____Treatment: _____
Diagnosed by doctor? _____Date:_____
Uses: inhaler☐ nebulizer☐ other medication☐
Taken: at home only☐ may need medication at school☐

• Attention Deficit Disorder Yes ☐
Is the student currently taking medication? No☐ Yes☐
Name of medication:_____ Dose (mg):_____
How often does he/she take it? _____

OVER PLEASE

• Bee sting allergy Yes ☐ Describe reaction: _____
Difficulty breathing No☐ Yes☐
Need emergency medication? No☐ Yes☐

• Bone, joint problems or broken bones? Yes ☐ Describe: _____
Any physical restrictions? _____

• Diabetes Yes ☐ Requires insulin? No☐ Yes☐ Date Diagnosed: _____

• Dizziness, loss of consciousness, fainting or loss of memory? Yes☐

• Heart condition, murmur, or irregular heart beat? Yes ☐ Describe: _____
Any physical restriction? No☐ Yes☐
What are they? _____ Medication? No☐ Yes☐

• Past history of increased lead levels in the blood? Yes ☐ When? _____ What was the level? _____

• Loss of an eye, kidney, testicle or other organ? Yes ☐ _____

• Previous head injury? Yes ☐ Age: _____ Describe: _____

• Seizures? Yes ☐ Type of seizure: _____
Date of last seizure: _____ Medication: _____
Is the student currently under s a doctor's care for seizure?
No☐ Yes☐

Has the student had any other illness? _____
Does the student take other daily medication at home? No ☐ Yes ☐ **At school?** No ☐ Yes ☐
Name of medication: _____Reason for taking it: _____
Has the student had any condition which required emergency treatment or hospitalization? No ☐ Yes ☐

If yes, for what?	Age	How long in hospital?	Surgeries?
_____	____	_____	_____

Check off the following health categories/concerns that pertain to the student?
<> Eyes: ☐wears glasses ☐wears contacts: ☐for reading ☐for distance ☐all the time
<> Ears: ☐frequent infections ☐ear tubes present Date: _____
wears hearing aid; ☐ right ear ☐left ear ☐ hearing difficulty: explain: _____
<> Other: ☐nosebleeds ☐requires diapering ☐sleeping difficulties ☐eating too little
☐headaches/migraines ☐requires catheterization ☐dental concerns ☐eating too much
☐bowel ☐bladder ☐bed wetting ☐menstruation ☐phobias

Does the student have any medical, physical, learning, or emotional problems that the school should know about?
(handicaps; parents recently separated; etc.) _____

Has your student been evaluated by any of the following professionals? (in the last 12 months):

☐audiologist ☐occupational therapist ☐psychologist ☐speech/language therapist
☐neurologist ☐physical therapist ☐psychiatrist ☐other: _____

Please list any other health concerns you have for the student. _____

_____
Parent/ Guardian signature Date

MAMARONECK UNION FREE SCHOOL DISTRICT

Mamaroneck, NY 10543

DENTIST CERTIFICATE

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Name:_____ Date of Birth:_____

Home Address:_____

School:_____ Grade Level:_____ Teacher:_____

TO BE COMPLETED BY DENTIST:

Date of Last Examination:_____

Check work that was completed at the last examination:

__Inspection __Cleaning __Repair __No Treatment

Please provide any information about the child's dental health that the school nurse should be aware of:

_____
_____
_____
_____
_____

Name of Dentist (please print):_____ Phone:_____

Signature:_____ Date:_____

Dentist Office Stamp (required):

Mamaroneck Union Free School District

LEAD SCREENING NOTICE

Date: _____

Child's Name: _____

NYS Public Health Law 67-1.4 Lead Screening states:

- Prior to or within three months of initial enrollment, each child care provider, public and private nursery school and preschool, licensed, certified or approved by any State or local agency shall obtain a written statement signed by a health care provider that documents lead screening for any child at least one year of age but under six years of age, and retain such documentation until one year after the child is no longer enrolled.
- When no documentation of lead screening exists, the child shall not be excluded from attending nursery school,, preschool, or childcare, however, the child care provider, principal, teacher, owner or person in charge of the nursery school or preschool shall provide the parent or guardian of the child with information on lead poisoning and lead poisoning prevention and refer the parent or guardian to the child's primary health care provider or, if the child's primary care provider is unavailable or the child has no primary health care provider, to another primary care provider or to the local health unit to obtain a blood lead test.

The child's cumulative health record must indicate either the date of the lead screening or that information on lead poisoning referral was provided.

The Health Office has not yet received LEAD SCREENING results on your child. This record must be received in order to comply with the New York State regulations.

Please send this information in as soon as possible. Thank you for your cooperation.

Please have your child's physician/practitioner complete below and return this letter to the school nurse.

Lead Level: _____ **Date of test: _____**

Physician/practitioner signature: _____

Physician/practitioner name printer: _____

Address: _____

Cc: copy of Lead Poisoning information

9/13/19

What Your Child's Blood Lead Test Means

The blood lead test tells you how much lead is in your child's blood. Lead can harm a child's growth, behavior, and ability to learn. The lower the test result, the better.

Most lead poisoning occurs when children lick, swallow, or breathe in dust from old lead paint. Most homes built before 1978 have old lead paint, often under newer paint. If paint peels, cracks, or is worn down, the chips and dust from the old lead paint can spread onto floors, windowsills, and all around your home. Lead paint dust can then get onto children's hands and toys, and into their mouths.

Most children have had some contact with lead in old paint, soil, plumbing, or another source. This is why New York State requires doctors to test all children with a blood lead test at age 1 year and again at age 2 years. For children up to age six years, your doctor or nurse should ask you at every well child visit about ways your child may have had contact with lead. Children who have had contact with lead should be tested.

A test result of 5 µg/dL or greater, using blood from a fingertip, should be checked again with a second test using blood taken from a vein (often in the arm). If the second result is still 5 µg/dL or greater, you should follow the steps below.

Test Result in micrograms per deciliter (µg/dL)	**Next Steps**
0-4	• **There is very little lead in your child's blood.** • The average lead test result for young children is about 1.4 micrograms per deciliter (µg/dL).
5-14	• **Your child's lead level is high. A result of 5 µg/dL or higher requires action.** • Your doctor or nurse will talk with you about your child's diet, growth and development, and possible sources of lead. • Your local health department will talk with you about how to protect your child and will visit your home to help you find sources of lead. • Your child should be tested again in 1 to 3 months.
15-44	• **Your child's lead level is quite high. You and your doctor should act quickly.** • Your doctor or nurse will talk with you about your child's diet, growth and development, and possible sources of lead. • Your local health department will talk with you about how to protect your child and will visit your home to help you find sources of lead. • Your child should be tested again in 1 month or sooner depending on the blood lead level and your doctor's guidance.
45 or higher	• **Your child needs medical treatment right away.** • Your doctor or local health department will call you as soon as they get the test result. • Your child might have to stay in a hospital, especially if your home has lead. • Your local health department will visit your home to help you find sources of lead. • Your child should not go back home until the lead sources are removed or fixed. • Your child needs to be tested again after treatment.

Child's Name: _____ Test Result: _____ µg/dL Date: _____

If the test result is not written here, ask your doctor or nurse for it, write it down, and save for your records.

For all test results, follow the advice on the other side to keep your child's lead level from rising.

How to Protect Your Child From Lead Poisoning

Fix peeling lead paint and make home repairs safely.

- Keep children away from peeling or chipped paint.
- Before making repairs in a home built before 1978, call your local health department to learn how to work safely and keep dust levels down.
- Children and pregnant women should stay away from repairs that disturb old paint, such as sanding and scraping. They should stay away until the area is cleaned using wet cleaning methods and a HEPA vacuum (not dry sweeping).

Wash dust off hands, toys, bottles, windows, and floors.

- Wash your child's hands and face after play, before meals, and before bed.
- Wash toys, stuffed animals, pacifiers and bottles with soap and water often.
- Mop floors often, and use damp paper towels to clean window wells and sills.

Be careful not to bring lead home on clothes, toys, or jewelry.

- Lead is in some children's jewelry, toys, keys, and old furniture. Sign up for children's product recall alerts at www.cpsc.gov/cpsclist.aspx.
- Some jobs and hobbies can involve contact with lead. These include: painting, plumbing, construction, car repair, working with firearms, stained glass, and pottery. To lower lead dust, change work clothes before going home; take shoes off at your door; wash work or hobby clothes separately; wash face, hands and uncovered skin before going home.

Keep lead out of your food and tap water.

- Let tap water run for one minute before using it, if it hasn't been run for a few hours. Town and well water could have lead from old plumbing.
- Only use cold tap water for drinking, cooking, and making baby formula. Boiling your water does not get rid of lead.
- Don't serve or store food in pewter, crystal, or cracked pottery.
- Call your health department, or visit the website below, to see which dishes, spices, candy, cosmetics, and health remedies have been found to have lead.

Serve foods that have calcium, iron, and vitamin C.

These foods help keep lead from being stored in your child's body.

- Foods with calcium: milk, cheese, yogurt, tofu, and green vegetables.
- Foods with iron: beans, lean meat, fortified cereal, and peanut butter.
- Foods with vitamin C: oranges, grapefruit, tomatoes, and green peppers.

Find out more about lead.

www.health.ny.gov/lead

Talk with your child's health care provider.

Call your local health department. Find them at www.health.ny.gov/environmental/lead/exposure/childhood/program_contact_map.htm

To: MUFSD Families

Please note **all health forms** can be found on the district website.

For physical exams:

- www.mamkschools.org
- Tools
- Parent Tab
- School Health Forms
- Individual Health Forms
    - Physical Exam Certificate
    - Vaccination Administration Form
    - Dental Certificate
    - TB form

For medication order forms and action plans:

- www.mamkschools.org
- Tools
- Parent Tab
- School Health Forms
- Health Information for Parents
    - Medication Permission Form
    - Allergy, Asthma, Seizure Emergency Action Plans

Warm regards,

MUFSD Nurses