



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

Janice Tieri, RN, Bennett School  
Sabrina Blakely, RN, High School  
Karen Hansen, RN, Middle School  
Heather Kight, RN, Woodstock School



Estimados Padres / Tutores;

Esperamos darle la bienvenida a su hijo(a) de regreso a la escuela en septiembre. La salud y la seguridad de los estudiantes y personal se revisan y actualizan constantemente. Nuestra principal prioridad es mantener un entorno seguro y saludable para todos.

Tenga en cuenta que cuando los estudiantes regresen en septiembre las vacunas deben estar al día o haber sido aprobadas como en proceso (esto debe seguir el Comité Asesor sobre Prácticas de Inmunizaciones [ACIP] cronograma). Recibirá un aviso de la enfermera de la escuela de su hijo(a) si su hijo(a) requiere alguna vacuna. Si su hijo(a) tiene una exención médica para la vacunación, el proveedor de atención médica (HCP) de su hijo(a) debe completar una nueva solicitud y enviarla a la escuela para su aprobación final cada año. Comuníquese con la enfermera de la escuela de su hijo(a) si tiene alguna pregunta o inquietud.

Todos los nuevos ingresos y estudiantes en los grados K,1, 3,5,7,9,y 11 deben tener un examen físico actual en el archivo de la oficina de salud. Esta documentación, si aún no se ha presentado, se espera que sea entregada a la oficina de salud para el 30 de septiembre de 2023. Si la evaluación de la salud no se recibe para el 30 de septiembre, la enfermera de la escuela se comunicará con usted con respecto a un examen físico con su proveedor de atención primaria con la Directora Médica de la escuela. Se recomienda un certificado dental para todos los estudiantes que deben tener un examen físico actual en el archivo.

Por favor notifique a la enfermera de su escuela sobre cualquier cambio en la salud de su hijo(a); como nuevos medicamentos y nuevos diagnósticos, incluyendo COVID-19.

Los medicamentos, recetados o de venta libre, DEBEN tener una orden por escrito del HCP para que el medicamento se administre en la escuela. Los estudiantes solo pueden llevar ciertos medicamentos en su persona. El HCP debe completar el formulario de pedido de medicamentos y el formulario de certificación de autotransporte para que el/la estudiante pueda auto-transportarlo. Los formularios completados deben ser entregados a la enfermera de la escuela.

Los desinfectantes para manos a base de alcohol todavía se utilizan en la escuela. Si no desea que su hijo(a) use la mano desinfectante, envíe un aviso por escrito a la oficina de salud de que su hijo(a) NO debe usar los desinfectantes para manos a base de alcohol.

Adjunto encontrará una copia del formulario de evaluación de salud y un formulario de certificado dental. Los formularios mencionados en esta carta se pueden encontrar en la página web del Distrito, bajo formularios del distrito, Servicios de salud. Si tienes dificultad accediendo a cualquiera de los formularios, por favor comuníquese con la enfermera de la escuela de su hijo(a).

Atentamente,  
Enfermeras del Distrito Escolar Central de Onteora

Janice Tieri ,Enfermera,Escuela Bennett  
Sabrina Blakely, Engermera, Escuela Secundaria  
Karen Hansen, Enfermera, Escuela Secundaria  
Heather Kight, Enfermera, Escuela Woodstock

## LEGAL REQUIREMENTS

### Immunizations

New York state requires the following immunizations:

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

### Health Examinations

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

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

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

### Dental Certificates

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

### Vision and Hearing Screenings

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

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

## HEALTHY HABITS

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

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

# Onteora School District

## HEALTH INFORMATION



## Elementary School Nurses:

Heather Kight, RN-Woodstock

845-679-2316 Ext. 5140

Janice Tieri, RN-Bennett

845-657-2354 Ext 4140

## HEALTH OFFICE GOALS

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

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

## HOW WE HANDLE INJURIES AND ILLNESSES AT SCHOOL

*The health office is only allowed to provide immediate First Aid and temporary care if a student is injured or becomes ill at school. Under New York State Law, a nurse cannot diagnose a condition or provide more than first aid for an emergency.*

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

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

## WHAT YOU NEED TO TELL US

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

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

### Information about your child's health

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

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

Please include the following:

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

## ABSENCE FROM SCHOOL

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

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

## MEDICATIONS AT SCHOOL

Every effort should be made to avoid giving any medication in school. This includes

homeopathic remedies, prescription and non-prescription drugs (such as Ibuprofen, cough drops, antacids, etc.).

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

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

## REQUISITOS LEGALES

### Inmunizaciones

La ley del estado de Nueva York requiere las

siguientes vacunas:

- 5 DTaP Toxoides Difteria (solo 4 si el cuarto se administra a los 4 años de edad o después)
- 4 IPV Polio (sólo requieren 3 si el tercero se administra después de los 4 años).
- 1 refuerzo de Tdap para estudiantes de 6.º grado (después de los 10 años)
- 2 sarampión, paperas y rubéola (MMR)
- 3 Hepatitis B
- 2 Varicela

### Exámenes De Salud

La Ley del Estado Nueva York requiere evaluaciones de salud(exámenes físicos) para **todos los**

**estudiantes que ingresan a Kindergarten, Grado 1, Grado 3, Grado 5 todos los estudiantes de**

**CSE. La Oficina de Salud puede realizar estos exámenes, sin embargo, se recomienda a su profesional de la salud porque él o ella:**

- está familiarizado con la historia de su hijo(a).
- puede proporcionar las inmunizaciones necesarias.
- tiene instalaciones de diagnóstico que no se encuentran en las escuelas
- puede tratar o aconsejarle de inmediato sobre cualquier condición de salud que pueda encontrarse.

La Oficina de Salud proporcionará un formulario para que su médico lo use para dicho examen o puede imprimir uno del sitio web del distrito.

### Certificados dentales

Se recomienda que el dentista de su hijo(a) complete un certificado dental y lo entregue a la oficina de salud.

### Pruebas de visión y audición

El estado de Nueva York requiere exámenes de visión y audición para todos los nuevos entrantes y

para Kindergarten, Grado 1, Grado 3, Grado 5 y todos los estudiantes de CSE.

El examen de la vista incluirá visión de cerca, agudeza a distancia y percepción del color (solo para nuevos entrantes)

### HÁBITOS SALUDABLES

Sus hijos aprenderán mejor si practica hábitos saludables en el hogar.

- Tenga una hora regular para acostarse con su hijo(a). Los niños de grado primario necesitan al menos 10 horas de sueño cada noche.
- Ayude a su hijo(a) a comenzar cada mañana con suficiente tiempo para lavarse, comer un buen desayuno y lavarse los dientes.
- Asegúrese de que su hijo(a) coma comidas regulares. *El desayuno es especialmente importante.*
- Anime a su hijo(a) a comer alimentos saludables. Pruebe bocadillos como frutas, verduras crudas, yogur y queso.
- Enséñele a su hijo(a) a lavarse las manos regularmente, y siempre antes de comer y después de usar el baño.
- Ayude a su hijo(a) a elegir ropa limpia adecuada para la escuela. Los pantalones y las zapatillas de deporte son apropiados para los días en que tienen educación física.
- Siempre haga que su hijo(a) se vista apropiadamente para el clima. Los niños deben usar ropa abrigada para estar cómodos durante el recreo al aire libre y en sus viajes en autobús hacia y desde la escuela.
- Asegúrese de que su hijo(a) use un abrigo, gorro y guantes abrigados para ir a la escuela en invierno. También deben tener pantalones de nieve y botas impermeables para condiciones de lluvia o nieve.

# Distrito Escolar de Onteora

INFORMACIÓN DE SALUD



## Enfermeras Las Escuelas primarias:

Heather Kight, R.N.-Woodstock  
845-679-2316 Ext. 5140

Janice Tieri,, R.N.-Bennett  
845-657-2354ext. 4140

### METAS DE LA OFICINA DE SALUD

Los problemas de salud hacen que el aprendizaje sea más difícil. La enfermera de la escuela tiene los siguientes objetivos para apoyar la educación de su hijo(a):

- Mantener un ambiente saludable para que los niños puedan aprender de manera efectiva.
- Ayudar a cada niño a mantener el nivel de salud más alto posible.
- Identificar posibles problemas de salud y ayudar a las familias a abordarlos.
- Enseñar a los niños hábitos saludables.

### CÓMO MANEJAMOS LAS LESIONES Y ENFERMEDADES EN LA ESCUELA

*A la Oficina de Salud solo se le permite brindar primeros auxilios y atención temporal de inmediato si un estudiante se lesiona o se enferma en la escuela. Según la Ley del estado de Nueva York, una enfermera no puede diagnosticar una afección ni proporcionar más que primeros auxilios para una emergencia.*

- La enfermera de la escuela se encargará de los problemas menores y enviará a su hijo(a) a clase si no se necesita más atención. Si se necesita más cuidado:
- La escuela hará todo lo posible para comunicarse con un padre o tutor. Si no se puede contactar a un padre o tutor, la escuela llamará a los números de emergencia adicionales que haya proporcionado.
- Los padres o tutores son responsables del transporte y la atención adicional. La escuela ayudará a los padres o tutores a planificar el transporte al hogar o a un centro médico.
- Si su hijo(a) se va a casa temprano debido a fiebre, vómitos o diarrea, no los envíe de vuelta a la escuela hasta que

estén libres de síntomas durante 24 horas sin el uso de reductor de fiebre.

### LO QUE NECESITA DECIRNOS

**A Quién Contactar-Su información de De contacto debe mantenerse actualizada. Notifique a la oficina en cualquier momento que haya cambiado su información de contacto.**

La escuela envía a casa un formulario anual para que el padre / tutor lo actualice. Esto le dirá a la escuela cómo comunicarse con usted y con quién más comunicarse si no puede ser contactado.

#### Información sobre la salud de su hijo(a)

La escuela proporciona formularios de salud para que nos informe sobre las afecciones médicas existentes que su hijo(a) pueda tener y cualquier instrucción especial para responder a los problemas que puedan surgir.

**Asegúrese de completar el Resumen de salud anual y mantenerlo actualizado.**

Por favor incluya lo siguiente:

- Condiciones físicas o médicas crónicas
- Medicamentos que toma su hijo(a)
- Alergias a picaduras de insectos.
- Alergias a alimentos tales como leche, nueces, etc.
- Historial de cualquier reacción alérgica a medicamentos.

### AUSENCIA DE LA ESCUELA

Si su hijo(a) está ausente de la escuela, debe presentar una excusa por escrito que incluya el nombre del estudiante, la (s) fecha (s) de ausencia y el motivo de la ausencia. La nota debe estar firmada por un padre/una madre o tutor. Notifique a la enfermera de la escuela cuando su hijo(a) esté ausente y si su hijo(a) tiene una enfermedad contagiosa.

### MEDICAMENTOS EN LA ESCUELA

Se debe hacer todo lo posible para evitar dar cualquier medicamento en la escuela. Esto incluye remedios homeopáticos, medicamentos recetados y medicamentos sin receta (como ibuprofeno, pastillas para la tos, antiácidos, etc.)

Si su hijo(a) tiene tomar medicamentos durante el horario escolar, debe hacer lo siguiente:

- Presente **una solicitud por escrito de su profesional de atención médica** que incluya el nombre del medicamento, la dosis y la frecuencia.
- Proporcionar **una solicitud por escrito de un padre/una madre o tutor** para administrar el medicamento.
- Entregar el medicamento en el envase original etiquetado a la Oficina de Salud.
- (el medicamento debe mantenerse en la Oficina de Salud).
- El permiso del proveedor y los padres para administrar los formularios de medicamentos están disponibles en nuestro sitio web del distrito.

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

**TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

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

## STUDENT INFORMATION

|                                                                                      |                                                                                                                                              |            |
|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Name:                                                                                | Affirmed Name (if applicable):                                                                                                               | DOB:       |
| Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male | Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X |            |
| School:                                                                              | Grade:                                                                                                                                       | Exam Date: |

## HEALTH HISTORY

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

|                                    |                                                                                                                                                                                                                              |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Allergies | Type:<br><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:<br><input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached |
| <input type="checkbox"/> Seizures  | Type: _____ Date of last seizure: _____<br><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<br><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:                                                                                       |
| Laboratory Testing     | Positive                 | Negative                 | Date   | Lead Level<br>Required for PreK & K                                                                 |
| TB- PRN                | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$ |
| Sickle Cell Screen-PRN | <input type="checkbox"/> | <input type="checkbox"/> |        |                                                                                                     |

☐ System Review Within Normal Limits

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

|                                        |                                         |                                          |                                       |                                           |
|----------------------------------------|-----------------------------------------|------------------------------------------|---------------------------------------|-------------------------------------------|
| <input type="checkbox"/> HEENT         | <input type="checkbox"/> Lymph nodes    | <input type="checkbox"/> Abdomen         | <input type="checkbox"/> Extremities  | <input type="checkbox"/> Speech           |
| <input type="checkbox"/> Dental        | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Back/Spine/Neck | <input type="checkbox"/> Skin         | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Lungs          | <input type="checkbox"/> Genitourinary   | <input type="checkbox"/> Neurological | <input type="checkbox"/> Musculoskeletal  |

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code\*

☐ Additional Information Attached

\*Required only for students with an IEP receiving Medicaid

|                                                                                                                                                                                                                                                                   |                                                                          |                                                                  |                                                                                      |                              |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------|--------------------------|
| Name:                                                                                                                                                                                                                                                             |                                                                          | Affirmed Name (if applicable):                                   |                                                                                      | DOB:                         |                          |
| <b>SCREENINGS</b>                                                                                                                                                                                                                                                 |                                                                          |                                                                  |                                                                                      |                              |                          |
| Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11                                                                                                                                                                                              |                                                                          |                                                                  |                                                                                      |                              |                          |
| <b>Vision Screening</b>                                                                                                                                                                                                                                           | With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No | Right                                                            | Left                                                                                 | Referral                     | Not Done                 |
| Distance Acuity                                                                                                                                                                                                                                                   |                                                                          | 20/                                                              | 20/                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| Near Vision Acuity                                                                                                                                                                                                                                                |                                                                          | 20/                                                              | 20/                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| Color Perception Screening                                                                                                                                                                                                                                        | <input type="checkbox"/> Pass <input type="checkbox"/> Fail              |                                                                  |                                                                                      |                              | <input type="checkbox"/> |
| Notes                                                                                                                                                                                                                                                             |                                                                          |                                                                  |                                                                                      |                              |                          |
| <b>Hearing Screening:</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.                                                                                              |                                                                          |                                                                  |                                                                                      |                              | <b>Not Done</b>          |
| Pure Tone Screening                                                                                                                                                                                                                                               | Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail        | Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail | Referral <input type="checkbox"/> Yes                                                |                              | <input type="checkbox"/> |
| Notes                                                                                                                                                                                                                                                             |                                                                          |                                                                  |                                                                                      |                              |                          |
| Scoliosis Screening: Boys grade 9, Girls grades 5 & 7                                                                                                                                                                                                             |                                                                          | Negative                                                         | Positive                                                                             | Referral                     | Not Done                 |
|                                                                                                                                                                                                                                                                   |                                                                          | <input type="checkbox"/>                                         | <input type="checkbox"/>                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> |
| <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> <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. |                                                                          |                                                                  |                                                                                      |                              |                          |
| <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V                                                                                                   |                                                                          |                                                                  |                                                                                      |                              |                          |
| <input type="checkbox"/> <b>Other Accommodations*:</b> Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):                                                                                                                             |                                                                          |                                                                  |                                                                                      |                              |                          |
| <small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>                                                                                                              |                                                                          |                                                                  |                                                                                      |                              |                          |
| <b>MEDICATIONS</b>                                                                                                                                                                                                                                                |                                                                          |                                                                  |                                                                                      |                              |                          |
| <input type="checkbox"/> Order Form for medication(s) needed at school attached                                                                                                                                                                                   |                                                                          |                                                                  |                                                                                      |                              |                          |
| <b>COMMUNICABLE DISEASE</b>                                                                                                                                                                                                                                       |                                                                          |                                                                  | <b>IMMUNIZATIONS</b>                                                                 |                              |                          |
| <input type="checkbox"/> Confirmed free of communicable disease during exam                                                                                                                                                                                       |                                                                          |                                                                  | <input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS |                              |                          |
| <b>HEALTHCARE PROVIDER</b>                                                                                                                                                                                                                                        |                                                                          |                                                                  |                                                                                      |                              |                          |
| Healthcare Provider Signature:                                                                                                                                                                                                                                    |                                                                          |                                                                  |                                                                                      |                              |                          |
| Provider Name: <i>(please print)</i>                                                                                                                                                                                                                              |                                                                          |                                                                  |                                                                                      |                              |                          |
| Provider Address:                                                                                                                                                                                                                                                 |                                                                          |                                                                  |                                                                                      |                              |                          |
| Phone:                                                                                                                                                                                                                                                            |                                                                          |                                                                  | Fax:                                                                                 |                              |                          |
| <b>Please Return This Form to Your Child's School Health Office When Completed.</b>                                                                                                                                                                               |                                                                          |                                                                  |                                                                                      |                              |                          |



## HEALTH SUMMARY

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

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

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

Current Physician/Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last visit to physician: \_\_\_\_\_ Reason: \_\_\_\_\_

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

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

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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?

---

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)

---

Signature

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Printed name:

---

Date:

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# NTEORA

## CENTRAL SCHOOL DISTRICT

### RESUMEN DE SALUD DEBE RENOVARSE ANUALMENTE

Nombre del estudiante: \_\_\_\_\_ Teléfono: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_ Grado: \_\_\_\_\_  
Dirección actual: \_\_\_\_\_

**Tenga en cuenta:** Las preocupaciones sobre la salud de los estudiantes, que incluyen, entre otras: alergias a los alimentos/alergias a las picaduras de abejas, diabetes, problemas respiratorios, convulsiones o cualquier problema de salud que pueda interferir con el aprendizaje de su hijo(a), se compartirán con los maestros del salón de clases y el personal apropiado que "necesita saber" a menos que especifique lo contrario al notificar a la enfermera de la escuela.

Médico/proveedor de atención médica actual: \_\_\_\_\_ Teléfono: \_\_\_\_\_  
Fecha de la última visita al médico: \_\_\_\_\_ Motivo: \_\_\_\_\_

¿Este niño(a) ha tenido alguno de los siguientes durante el último año? (En caso afirmativo, explique en el espacio provisto)

- ❖ Lesiones graves que requieren atención médica. \_\_\_\_\_
- ❖ Enfermedad u operaciones graves \_\_\_\_\_
- ❖ Visitas a la sala de emergencias para recibir tratamiento. \_\_\_\_\_
- ❖ Cambios en el uso de anteojos o lentes de contacto \_\_\_\_\_
- ❖ Nuevas alergias diagnosticadas \_\_\_\_\_
- ❖ Enfermedad crónica diagnosticada \_\_\_\_\_
- ❖ Asma o problemas respiratorios Ataques/Convulsiones \_\_\_\_\_
- ❖ COVID-19 \_\_\_\_\_

¿Este niño(a) está recibiendo algún medicamento recetado? (Si es así, por favor enumere)

¿Ha recibido este niño(a) alguna vacuna desde el año pasado? (Si es así, enumere las fechas y el proveedor)

¿Hay cambios o dificultades en la familia que puedan influir en el rendimiento o el comportamiento escolar?

¿Hay otros servicios o agencias involucradas con su hijo(a) o familia? (por ejemplo, consejeros, terapeutas, agencias de servicios sociales. Si es así, enumere)

¿Hay alguna otra información sobre la salud y el bienestar de este niño(a) que sea importante para una experiencia escolar exitosa este año? (Si es así, por favor descríbalos)

Completado por:

Escriba el nombre \_\_\_\_\_ Relación con el/la estudiante: \_\_\_\_\_ Fecha: \_\_\_\_\_

Firma \_\_\_\_\_



Bennett 657-2354  
Fax: 845-657-8504

Middle/High 657-2373  
Fax: 845-657-8430

Woodstock 679-2316  
Fax: 845-679-1207

**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

\_\_\_\_\_  
Phone

**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.

Prescriber's signature \_\_\_\_\_ Date: \_\_\_\_\_

stamp

**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: \_\_\_\_\_



### **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.

### Recordatorio importante

Queridos Padres/Tutores:

Todas las escuelas del distrito de Oteora son escuelas "conscientes de las nueces". Este procedimiento se ha implementado con el fin de proporcionar un entorno seguro para los estudiantes alérgicos a las nueces (maní / nueces de árbol). Una reacción anafiláctica (severa) puede ser devastadora para el estudiante o los estudiantes que presencian la reacción.

Se siguen los siguientes pasos:

- La cafetería no ofrece crema de maní, solo sunbutter. Los estudiantes pueden seleccionar otras opciones disponibles, pavo, atún, jamón y / o queso, o sándwich de mermelada y sunbutter. Los bocadillos y cereales proporcionados no contienen productos de maní. Nota: en la escuela secundaria, algunos bocadillos pueden contener productos de nueces. Se recuerda a todos los estudiantes y al personal que observen las señales y lean las etiquetas.
- Hay mesas designadas libres de nueces en las cafeterías de la escuela primaria, que se limpian con diferentes artículos de limpieza. No se permiten productos de nueces en las mesas designadas. No hay mesas libres de nueces en la escuela intermedia / secundaria. Se permitirá comer crema de nueces (maní / avellana) en la cafetería, en mesas alejadas de la mesa sin nueces. Alentamos a minimizar el envío de bocadillos de crema de maní o nueces. Todos los niños que consumen frutos secos deben lavarse las manos después de comer. *Si un niño alérgico a las nueces / maní toca un artículo después de que alguien que haya tocado el mismo artículo con aceite de nueces en sus manos, podría ocurrir una reacción severa.*
- Todas las salas comunes son conscientes de las nueces. Si un estudiante trae un artículo con nueces, seguirá el mismo procedimiento que en la cafetería (ver arriba). Reconocemos que las nueces son un bocadillo bueno y saludable para la mayoría de los niños. También sabemos que los estudiantes están en la escuela solo 6 horas al día y que hay otros bocadillos que son igualmente saludables y ayudarán a otros en nuestra comunidad escolar a mantenerse seguros.
- Los maestros del salón de clases determinarán si el salón de clases está libre de nueces o establecerán un área libre de nueces, usando las mismas precauciones que la cafetería.
- La enfermera de la escuela y / o el maestro discutirán las alergias alimentarias con todas las clases de la escuela. El personal de la cafetería revisará los procedimientos libres de nueces en la cafetería al comienzo del año escolar y durante todo el año según sea necesario.
- Los miembros del personal recibirán capacitación en el uso de Epi-Pen si corresponde para estudiantes específicos.
- Los padres deben consultar con la enfermera de la escuela y / o el maestro del salón de clases antes de traer bocadillos para el salón de clases por cualquier alergia.
- La investigación y los materiales sobre esta condición y cómo otras escuelas abordan la misma situación se revisan continuamente.

Es nuestra responsabilidad minimizar el riesgo para todos nuestros estudiantes en la mayor medida posible. Ningún niño debería tener miedo de ir a la escuela por temor a tener una reacción potencialmente mortal. Estos cambios menores reducen significativamente el riesgo para todos nuestros niños.

No dude en comunicarse con el director/la directora de la escuela de su hijo/a o la enfermera de la escuela si tiene alguna inquietud. Trabajaremos con usted para ayudarlo a encontrar una solución a sus inquietudes.

Gracias por ayudarnos a mantener seguros a todos los niños.

# Onteora Central School District

## Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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: / / Sex: ☐ Male ☐ Female Will this be your child's first oral health assessment? ☐ 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/ 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): \_\_\_\_\_

#### 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.

# ONTEORA CENTRAL SCHOOL DISTRICT

Escuela secundaria – (845)657-2373, Bennett Primaria – 657-2354, Woodstock Primaria 679-2316

## Certificado de Salud Dental - Opcional

Padres/Tutores: La ley del estado de Nueva York (Capítulo 281) permite que las escuelas soliciten una evaluación de salud bucal al mismo tiempo que se requiere un examen de salud. Su hijo/a puede tener un chequeo dental durante este año escolar para evaluar su aptitud para asistir a la escuela. Complete la Sección 1 y lleve el formulario a su dentista o higienista dental registrado para que lo evalúen. Si su hijo/a tuvo un chequeo dental antes de comenzar la escuela, pídale a su dentista o higienista dental que complete la Sección 2. Devuelva el formulario completo a la directora médica o a la enfermera de la escuela lo antes posible.

### Sección 1. Para ser completada por los padres o tutores (en letra de imprenta)

|                                          |     |                                                                                                                       |        |                |
|------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------|--------|----------------|
| Estudiante:                              |     | Apellido                                                                                                              | Nombre | Segundo nombre |
| Fecha de nac.:                           | /   | /                                                                                                                     |        |                |
| Mes                                      | Día | Año                                                                                                                   |        |                |
| Sexo: <input type="checkbox"/> Masculino |     | ¿Será esta la primera evaluación de salud bucal de su hijo/a? <input type="checkbox"/> Sí <input type="checkbox"/> No |        |                |
| <input type="checkbox"/> Femenino        |     |                                                                                                                       |        |                |
| Escuela: Nombre                          |     |                                                                                                                       |        | Grado          |

¿Ha notado algún problema en la boca que interfiera con la capacidad de su hijo/a para masticar, hablar o concentrarse en las actividades escolares? ☐ Sí ☐ No

Entiendo que al firmar este formulario doy mi consentimiento para que el niño/la niña mencionado anteriormente reciba una evaluación básica de salud bucal. Entiendo que esta evaluación es solo un medio limitado de evaluación para evaluar la salud bucal del estudiante y que necesitaría contratar los servicios de un dentista para que mi hijo/a reciba un examen dental completo con radiografías, si es necesario, para mantener una buena salud bucal.

También comprendo que recibir esta evaluación preliminar de salud bucal no establece ninguna relación médico-paciente nueva, continua o permanente. Además, no responsabilizaré al dentista ni a quienes realicen esta evaluación por las consecuencias o los resultados si decido NO seguir las recomendaciones que se enumeran a continuación.

Firma de los padres \_\_\_\_\_ Fecha \_\_\_\_\_

### 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.