

**Harold J. Dean, Ed.D.**  
Superintendent of Schools

**Robert J. Scappatore**  
Assistant Superintendent / Principal

**Michael C. Gordon**  
Assistant Superintendent for PPS & Operations

**Kathleen A. Nolan**  
School Business Manager / District Treasurer



**2460 North Wading River Road**  
Wading River, New York 11792  
**Tel (631) 929-4300**  
**Fax (631) 929-0303**

**Board of Education**  
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Steven D. Gellar  
Nancy H. Hancock  
Dr. Bridgette Waite

Dear Parent/Guardian:

The following pages include several forms that must be completed by you and/or your child's physician for the upcoming 2025-26 school year. A description of each form can be found below.

1. **Emergency Contact Form**  
Contact information for you and additional contacts; **MUST** include medications your child is on, both prescribed and over the counter (vitamins, ibuprofen, etc.).
2. **NYS Health Examination Form**  
Your child's doctor must provide evidence of a physical examination. If the doctor's office does not have a form they provide, the enclosed blank form can be completed by the doctor's office.
3. **Immunization Records**  
Your child's doctor must provide a copy of your child's current immunizations.
4. **Meningitis Vaccination Check-off**  
A form required for completion for residential schools advising parents/guardians/students of the risks associated with meningitis.
5. **Medication Authorization**  
Applicable to students who require medications to be dispensed during the day, with a licensed healthcare provider completing and signing the medication information.

**Please complete and return the requested information below by September 15th. If we do not receive the required information, there is the possibility enrollment can be suspended until all information is received.**

Should you have any questions, please contact the main office at 631-929-4300.

Thank you,

Robert J. Scappatore  
Principal

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**Emergency Contact Form**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Emergency Contacts

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Parent/Guardian Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other Adult Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact #1 \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Phone: \_\_\_\_\_

Mental Health Information (Over the counter and prescription)

<b>Current Medications:</b>	<b>Times per day</b>	<b>When taken</b>
_____		_____
_____		

<b>Allergies (list):</b>	<b>Reaction</b>
_____	_____
	_____

Medical Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Psychiatrist Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**In the event that I or the others listed above are unavailable, I give my permission to the school nurse or, in her absence, the LFC&FS nurses, to provide first aid for the student named above and to take appropriate measures including contacting the emergency medical services (EMS) system and arranging for transportation and treatment at the nearest emergency medical facility.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

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### Authorization for Administration of Medication

To be completed by the parent or guardian:

If your child is to receive medications during the day; please read and fill out the attached Authorization for Administration of Medication form. Our nurses are not allowed to disburse any medications without this completed form signed by your doctor.

I request that my child \_\_\_\_\_ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her medication.

Signature (Parent or Guardian): \_\_\_\_\_

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

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Date \_\_\_\_\_

To be completed by the licensed health care provider:

I request that my patient, as listed below, receive the following medication (s):

Name of Student: \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency: \_\_\_\_\_

Time to be Taken During School Hours: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

1. Have pharmacist fill & label a separate bottle for the school (complete with pill count)
2. Copy of child's medication prescription sent or brought to school (fax number 929-0303)
3. Medication must always be in the possession of an adult, never in the possession of a child
4. Over the counter medications: Original Container with student's name, also requires physician permission
5. Permission to administer medication in school has to be renewed by the parent/guardian and physician at the start of every school year.
6. If medication provided is running low, the nurse will notify the parent/guardian. A form will also be sent home notifying you that more medication is needed and by what date. The form will have space for the parent to indicate the date they are sending more medication as well as the number of pills they are sending.

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

**Allergies**  No  Medication/Treatment Order Attached  Anaphylaxis Care Plan Attached  
 Yes, indicate type  Food  Insects  Latex  Medication  Environmental

**Asthma**  No  Medication/Treatment Order Attached  Asthma Care Plan Attached  
 Yes, indicate type  Intermittent  Persistent  Other : \_\_\_\_\_

**Seizures**  No  Medication/Treatment Order Attached  Seizure Care Plan Attached  
 Yes, indicate type  Type: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

**Diabetes**  No  Medication/Treatment Order Attached  Diabetes Medical Mgmt. Plan Attached  
 Yes, indicate type  Type 1  Type 2  HbA1c results: \_\_\_\_\_ Date Drawn: \_\_\_\_\_

**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:**  No  Yes **Hypertension:**  No  Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_ **Respirations:** \_\_\_\_\_

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

**System Review and Exam Entirely Normal**

**Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities**

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<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

Name:			DOB:	
<b>SCREENINGS</b>				
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys grade 9 And girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
<b>Recommendations:</b>				
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>				
<input type="checkbox"/> <b>Full Activity</b> without restrictions including Physical Education and Athletics.				
<input type="checkbox"/> <b>Restrictions/Adaptations</b> Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
<input type="checkbox"/> <b>No Contact Sports</b> <b>Includes:</b> baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
<input type="checkbox"/> <b>No Non-Contact Sports</b> <b>Includes:</b> archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
<input type="checkbox"/> <b>Other Restrictions:</b>				
<input type="checkbox"/> <b>Developmental Stage for Athletic Placement Process ONLY</b> Grades 7 & 8 to play at high school level <b>OR</b> Grades 9-12 to play middle school level sports Student is at <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>Accommodations:</b> Use additional space below to explain				
<input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids				
<input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator*				
<input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
<b>MEDICATIONS</b>				
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School attached</b>				
<b>List medications taken at home:</b>				
<b>IMMUNIZATIONS</b>				
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>HEALTH CARE PROVIDER</b>				
Medical Provider Signature:				<b>Date:</b>
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
<b>Please Return This Form To Your Child's School When Entirely Completed.</b>				

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New York State Public Health Law requires that all parents or guardians of residential school students (or residential students 18 years of age and older) in grades 7-12, complete and return the following form to Little Flower UFSD.

Check one box and sign below.

My child has (for students over the age of 18: I have):

- Had the meningococcal meningitis immunization (Menomune) with the past 10 years.

Date Received: \_\_\_\_\_

[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered with 3-5 years.]

Please provide your child's most recent immunization records with this form.

- Read, or have had explained to me, the information regarding meningococcal meningitis disease.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Print Student's Name \_\_\_\_\_

Student DOB \_\_\_/\_\_\_/\_\_\_

E-Mail Address \_\_\_\_\_

Student ID# \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone Number \_\_\_\_\_

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Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. New York State Public Health Law (NYS PHL) 2167 was signed into law on July 22, 2003 requiring residential schools to distribute information about meningococcal disease and vaccination to all students in grades 7-12. This law became effective on August 15, 2003.

Little Flower School is required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student or student's parent or guardian. This must include information on the availability and cost of the meningococcal meningitis vaccine (Menactra); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or student's parent or guardian.

*Meningococcal meningitis is rare.* However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningococcal meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

The vaccine Menactra is 85% to 100% effective in preventing the four types of meningococcal disease (types A, C, Y, W-135). These four types cause about 70% of the disease in the United States. Because the vaccine does not include type B, which accounts for about one-third of cases in adolescents, it does not prevent all cases of meningococcal disease.

Our school district does not provide the vaccine, the nurse in the Little Flower Infirmary can provide you with resources to assist with obtaining this vaccine.

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**PHOTO/VIDEO RELEASE**

Dear Parent/Guardian:

Throughout the school year, our students participate in many educational activities and celebrations. These activities and celebrations are very rewarding for our students. As an educational community we find that by honoring, recognizing and promoting our student's educational efforts and activities it fosters a better self-image for the student. With this in mind, we would like your permission for the Little Flower School District ("the School") and Little Flower Children and Family Services of New York ("the Agency") to record and use your son/daughter's voice and image in picture, video and/or audiotape and to use any images taken of them or produced by them for educational and publicity purposes associated with the Agency, the School and its programs and services. I authorize the Agency and the School to use these images and student work in any and all media now known or hereafter discovered or developed.

I represent that I am a parent/guardian of the minor named above and I agree that the grant and release contained therein binds us and said minor to all of the terms thereof.

Child's Name \_\_\_\_\_

Parent or Guardian's Name \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_