



HIGHLAND CENTRAL SCHOOL DISTRICT

MEDICAL PACKET

Dear Prospective Student and Parent/Guardian:

Welcome to the Highland Central School District! We wish you success in your studies and life here.

*It is our district policy for **out of state** students to provide proof of immunization **prior to entrance**. Students **within state** are granted a **two week period** after school starts to present proof of immunization. It is the **parents'** responsibility to provide these records, although, if requested, the school will assist in obtaining the records.*

It is vitally important to your child's health and safety that you complete the emergency contact form and the medical update and return them to the guidance office or at the enrollment session before the start of classes.

*Students are required by Article 19 of State Education Law to furnish a report of a **physical examination within the past year** for entrance to school. If the student has had such an examination, please forward a copy of it to the school. If the student needs a physical examination, the form in this packet may be used by your medical provider. Your student will receive an examination at school, if a report is not submitted to the school by October of that school year.*

*Students who need to **take medication at school**, during **sports** or during school sponsored **field trips**, **whether prescribed or over the counter**, will need a **note from their doctor and a note from a parent/legal guardian**. A form has been attached for your convenience.*

Kindly return the forms to the health office in your child's building:

Highland Elementary 691-1064

Highland Middle 691-1094

Highland High 691-1053

Thank you for your cooperation.



HIGHLAND CENTRAL SCHOOL DISTRICT

PAQUETE MÉDICO

Estimado estudiante potencial y padre/tutor:

¡Bienvenidos al Distrito Escolar Central de Highland! Te deseamos éxito en tus estudios y en tu vida aquí.

*Es política de nuestro distrito que los estudiantes **de fuera del estado** presenten prueba de inmunización **antes de entrar**. A los estudiantes **dentro del estado** se les concede un **periodo de dos** semanas tras el inicio de las clases para presentar prueba de inmunización. Es **responsabilidad de los padres** proporcionar estos registros, aunque, si se solicita, el colegio ayudará a obtenerlos.*

Es vital para la salud y seguridad de tu hijo que completes el formulario de contacto de emergencia y la actualización médica y los devuelvas a la oficina de orientación o en la sesión de inscripción antes del inicio de las clases.

*El Artículo 19 de la Ley Estatal de Educación exige a los estudiantes presentar un informe de un **examen físico realizado en el último año** para poder acceder a la escuela. Si el estudiante ha realizado un examen de este tipo, por favor envíe una copia al colegio. Si el estudiante necesita un examen físico, el formulario de este paquete puede ser utilizado por su proveedor médico. Tu estudiante recibirá un examen en la escuela si no se presenta un informe antes de octubre de ese curso escolar.*

*Los estudiantes que necesiten **tomar medicación en el colegio**, durante **deportes o** durante excursiones **patrocinadas por el colegio**, **ya sea prescrita o sin receta**, deberán una **nota de su médico y una de un padre o tutor legal**. Se ha adjuntado un formulario para su comodidad.*

Por favor, devuelve los formularios a la oficina de salud del edificio de tu hijo:

Highland Elementary 691-1064

Highland Middle 691-1094

Highland High 691-1053

Gracias por su ayuda.



HIGHLAND CENTRAL SCHOOL DISTRICT

MEDICAL PACKET

Dear Parent/Guardian:

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings will be required or completed at school:

Vision

- Distance acuity for all **newly entering students** and students in **Kindergarten, Grades 1, 3, 5, 7 and 11.**
- Near vision acuity and color perception screening for all newly entering students.

Hearing

- Hearing screening for all **newly entering students** and students in **Kindergarten, Grades 1, 3, 5, 7 and 11.**

Scoliosis

- Scoliosis (spinal curvature) screening for all **male** students in Grades **9, female** students in Grades **5 and 7.**

Health Appraisals

- A physical examination including Body Mass Index and Weight Status Category Information is required for all **newly entering students** and students in **Kindergarten, Grades 1, 3, 5, 7, 9 and 11.**

Dental Certificates

- A dental certificate is requested for all **newly entering students** and students in **Kindergarten, Grades 1, 3, 5, 7, 9 and 11.**

Please call your child school's Health Office if you have any questions or concerns.

Elementary School Nurse's Office: (845)691-1065

Middle School Nurse's Office: (845)691-1085

High School Nurse's office: (845) 691-1025

Fax: 691-1064

Fax: 691-1094

Fax: 691-1053



PAQUETE MÉDICO

Estimado padre/tutor:

El programa de Servicios de Salud Escolar del distrito apoya el éxito académico de tu hijo promoviendo la salud en el entorno escolar. Una forma en la que ofrecemos atención a su estudiante es realizando los exámenes de salud establecidos por el Estado de Nueva York.

Durante este curso escolar, se requerirán o se completarán las siguientes proyecciones en el centro:

Visión

- Gravedad a distancia para todos **los estudiantes recién llegados** y de **Infantil, grados 1, 3, 5, 7 y 11.**
- Cribado de agudeza de visión cercana y percepción del color para todos los estudiantes recién ingresados.

Audiencia

- Cribado auditivo para todos **los alumnos recién** ingresados y alumnos de **Infantil, 1, 3, 5, 7 y 11** curso.

Escoliosis

- Cribado de escoliosis (curvatura espinal) para todos **los alumnos varones de 9 curso y alumnas de 5 y 7 curso.**

Valoraciones de salud

- Se requiere un examen físico que incluya el Índice de Masa Corporal e Información sobre la Categoría de Estado de Peso para todos **los estudiantes recién ingresados** y los alumnos de **Kindergarten, de 1, 3, 5, 7, 9 y 11** curso.

Certificados dentales

- Se solicita un certificado dental para todos los **estudiantes recién ingresados** y estudiantes de **Infantil, grados 1, 3, 5, 7, 9 y 11.**

Por favor, llama a la Oficina de Salud de tu escuela infantil si tienes alguna pregunta o inquietud.

Enfermería de Primaria: (845)691-1065 **Fax:** 691-1064
Enfermería de la Escuela Secundaria: (845)691-1085 **Fax:** 691-1094
Enfermería de secundaria: (845) 691-1025 **Fax:** 691-1053



HIGHLAND CENTRAL SCHOOL DISTRICT

PROVIDER AND PARENT PERMISSION TO ADMINISTER MEDICATION AT SCHOOL/SCHOOL SPONSORED EVENTS 26/27

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.

Parent/Guardian Signature

Date

Email

Phone Where We Can Reach You Check if Cell

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)

NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

Name/Title of Prescriber (Please Print)

Date

Stamp

Prescriber's Signature

Phone

Email

Return to:

School Nurse: _____ School: _____

School Address: _____

Phone: () _____ Fax: () _____ Email _____



HIGHLAND CENTRAL SCHOOL DISTRICT

PERMISO DEL PROVEEDOR Y DE LOS PADRES PARA
ADMINISTRAR MEDICAMENTOS EN LA ESCUELA/EVENTOS
PATROCINADOS POR LA ESCUELA 26/27

Debe ser completado por el padre

Nombre del estudiante: _____ fecha de nacimiento: _____

Curso: _____ Profesor/RRHH: _____ Colegio: _____

Le pido a la enfermera del colegio que me dé la medicación que aparece en este plan; o después de que la enfermera determine que mi hijo puede tomar su propia medicación; Personal cualificado puede ayudar a mi hijo a tomar su propia medicación. Proporcionaré la medicación en la farmacia original o en un envase de venta libre. Este plan se compartirá con el personal escolar que cuida de mi hijo.

Fecha de firma del padre/tutor

correo electrónico Teléfono donde podamos localizarte , comprueba si tienes móvil

Debe ser completado por un proveedor de atención sanitaria - válido durante 1 año

Diagnóstico _____

Medicación _____

Dosis _____ Ruta _____ Tiempo(s) _____

Recommendations _____ Código ICD _____

Nota: La medicación se administrará lo más cerca posible del tiempo prescrito, pero puede administrarse hasta una hora antes o después del tiempo prescrito. Por favor, informa si hay alguna preocupación específica respecto a la administración.

Atestación de Porte y Uso Independiente Adjunta (Requerida para Porte y Uso Independiente)

La ley de NY exige que ambos proveedores acrediten que el estudiante ha demostrado que puede autoadministrar eficazmente medicamentos respiratorios inhalados de rescate, autoinyección de epinefrina, insulina, suministro de glucagón y diabetes u otros medicamentos que requieran administración rápida junto con permiso de los padres o tutores para permitir esta opción en la escuela. Marque esta casilla y adjunte la declaración de atestación a este formulario para solicitar esta opción.

Nombre/Título del prescriptor (Por favor, imprimir) Fecha

Signature del Prescriptor Teléfono

Correo electrónico

Volver a:

Enfermera escolar: _____ Escuela: _____

Dirección: _____

Phone: _____ Fax: _____ Correo electrónico: _____

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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

BMI _____ kg/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
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	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"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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 <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"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> 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					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Dental Health Certificate

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.