

**BALDWIN UNION FREE SCHOOL DISTRICT
BALDWIN, NEW YORK**

FORM DO-6A
HEALTH HISTORY/
MEDICAL EXAMINATION

Dear Parents or Guardians:

New York State Education Law, Section 903 (amended) requires a physical examination by a licensed physician for all new entrants and also for students entering the Kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th grades.

We believe that it is preferable for your child to be examined by his or her own physician who knows your child best. If this is not possible, arrangements can be made for the school physician to do an examination.

Thank you,
Suanne Kowal-Connelly, M.D.
Chief School Physician

Name _____ Male _____ Female _____

School _____ Grade _____

Health History					
Disease	Date	Disease	Date	Disease	Date
Anemia	_____	German Measles*(1)	_____	Pneumonia	_____
Asthma	_____	Measles*	_____	Rheumatic Fever	_____
Chicken Pox*	_____	Mononucleosis	_____	Scarlet Fever	_____
Diabetes	_____	Mumps*	_____	Tuberculosis	_____
Diphtheria	_____	Poliomyelitis	_____	Typhoid Fever	_____
Ear Problems	_____			Whooping Cough	_____

(*Must be certified by a physician; (1)Must be confirmed by positive serology)

Has your child had any of the following? If yes, please specify:

Allergies _____
Birth Defect or Injury _____
Convulsions _____
Gastrointestinal Disorders _____
Heart Condition _____
Kidney Disease _____
Operations _____
Recurrent Infections _____
Serious Injuries _____
Hearing Loss _____
Visual Disturbance _____

Does your child require any medication on a regular basis (excluding vitamins)?

No _____ Yes _____ If yes, please specify _____

Parent/Guardian Signature: _____ Date: _____

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

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

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

BMI _____ kg/m2

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

Hyperlipidemia: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	☐	☐		

☐ **System Review Within Normal Limits**

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

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

☐ **Assessment/Abnormalities Noted/Recommendations:**

Diagnoses/Problems (list)

ICD-10 Code*

☐ **Additional Information Attached**

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail					☐
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail	Referral ☐ Yes		☐
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative ☐	Positive ☐	Referral ☐ Yes	Not Done ☐
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
☐ *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
☐ Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
☐ Student is restricted from participation in:					
☐ Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
☐ Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
☐ Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
☐ Other Restrictions:					
Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V					
☐ Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
☐ Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
☐ Confirmed free of communicable disease during exam			☐ Record Attached ☐ Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
*Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
 - c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
 - d. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 6 Years of Age](#).
 - e. For further information, refer to the [CDC Catch-Up Guidance for Children 7 through 9 Years of Age](#).
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 11: 10 years; minimum age for grade 12: 7 years).
 - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
 - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2025-26, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 11; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grade 12.
 - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
 - d. For further information, refer to the [CDC Catch-Up Guidance for Children 10 through 18 Years of Age](#).
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
 - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
 - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward New York State school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.
 - e. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 17 Years of Age](#).
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
 - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. Measles: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (pre-kindergarten through 12).
6. Hepatitis B vaccine
 - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
 - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
 - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 12: 10 years).
 - a. One dose of meningococcal conjugate vaccine is required for students entering grades 7, 8, 9, 10 and 11.
 - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
 - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
 - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
 - d. If dose 1 was received at 15 months or older, only 1 dose is required.
 - e. Hib vaccine is not required for children 5 years or older.
 - f. For further information, refer to the [CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age](#).
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
 - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
 - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
 - e. PCV is not required for children 5 years or older.
 - f. For further information, refer to the [CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age](#). *Depending on vaccine brand, schedule may change.

For further information, contact:

New York State Department of Health
Division of Vaccine Excellence
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
School Compliance Unit, Bureau of Immunization
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/immunization

**BALDWIN UNION FREE SCHOOL DISTRICT
NEW ENTRANT IMMUNIZATION FORM**

Student's Name _____ Date of Birth _____

School _____ Grade _____

New York State Law requires that all children entering school must present a certificate signed by a physician stating that they have been adequately immunized against **DIPHTHERIA, TETANUS, AND PERTUSIS, POLIOMYELITIS, MEASLES, MUMPS, RUBELLA, HEPATITIS B, AND VARICELLA (CHICKEN POX)**. Please have this form completed and signed by your child's physician and present it when you register your child. We accept a copy of the record from the doctor's office if it is signed and stamped. Thank you for your cooperation in this matter.

UNDER NEW YORK STATE LAW, PROOF OF ALL IMMUNIZATIONS MUST BE SUBMITTED BEFORE YOUR CHILD CAN ATTEND SCHOOL.

- | | | | | | |
|---|-------|-------|-------|-------|-------|
| 1. <u>POLIO (3-5 Doses)</u>
(If combination of IPV & OPV, must be 4 doses) | _____ | _____ | _____ | _____ | _____ |
| | Date | Date | Date | Date | Date |
| 2. <u>DIPHTHERIA, TETANUS and PERTUSIS (3-5 Doses)</u> | _____ | _____ | _____ | _____ | _____ |
| | Date | Date | Date | Date | Date |
| 3. <u>Tdap</u> (To be given at 11 yrs. of age) | _____ | | | | |
| | Date | | | | |
| 4. <u>PNEUMOCOCCAL VACCINE</u> (for PreK) | _____ | _____ | _____ | _____ | |
| | Date | Date | Date | Date | |
| 5. <u>MMR (2 Doses)</u> | _____ | _____ | | | |
| | Date | Date | | | |
| 6. <u>HiB (Haemophilus Influenza B)</u> (for PreK) | _____ | _____ | _____ | _____ | |
| | Date | Date | Date | Date | |
| 7. <u>HEPATITIS A (Recommended) (2 Doses)</u> | _____ | _____ | | | |
| | Date | Date | | | |
| 8. <u>HEPATITIS B (3 Doses)</u> | _____ | _____ | _____ | | |
| | Date | Date | Date | | |
| 9. <u>VARICELLA (CHICKEN POX) 2 Doses*</u> | _____ | _____ | | | |
| | Date | Date | | | |
| (Administered after one (1) year of age for children born on or after 1/01/98.) | | | | | |
| 10. <u>MCV Dose*</u> | _____ | _____ | | | |
| | Date | Date | | | |

(First Dose 7th Grade, second dose in 12th grade. If first dose given at 16 or older, no second dose necessary)

DATE: _____ PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S STAMP:

Revised 11/03, 5/07, 12/09, 12/16, 9/19, 11/20, 1/24



**BALDWIN
SCHOOLS**

Baldwin Union Free School District

960 Hastings Street ♦ Baldwin, NY 11510-4798

www.baldwinschools.org

 **Baldwin**
Public Schools
We are
We are
We are
We are

Gina Curcio

Assistant Director of Health, Wellness and Community Relations, PreK-12

Phone: 516-434-6081 ♦ FAX 516-434-6821

January 2026

Dear Parent/Guardian,

As you know, your children's health and safety are of paramount importance to us. With this in mind, we ask for your cooperation and careful attention to the following matter.

Numerous students in our school are **severely allergic** to specific foods, including milk, eggs, peanuts, and nut products. A reaction can occur if these are eaten and simply by touching them. This allergic reaction can be LIFE-THREATENING. Strict avoidance is the only way to prevent an allergic reaction.

We ask for your cooperation in maintaining a safe environment for all our children.

- If your child is in a classroom with a student with a food allergy, we ask that you avoid sending your child in with a snack or lunch that may contain peanuts.
- For birthday celebrations, we ask that you celebrate without food, as instructed by your building principal.
- Goodie Bags containing food are not permitted, as their contents may contain items that are allergic to some students, thus creating an adverse reaction and health hazard.

It is imperative that if your child does have an allergy, please make us aware immediately. In addition, please provide our nurse with scripts for any medications, even over the counter.

Only by creating a partnership between home and school can we ensure our children's health and safety.

Thank you for your understanding and cooperation in this most important matter. We can count on each of you to help maintain a safe environment for all our students.

If you have any questions or concerns, don't hesitate to contact the health office.

Sincerely,

Gina Curcio

Assistant Director of Health, Wellness and Community Relations, PreK-12

We are Innovative...We are Inclusive...We are Involved...We are Baldwin!



**BALDWIN
SCHOOLS**

Baldwin Union Free School District

960 Hastings Street ♦ Baldwin, NY 11510-4798

www.baldwinschools.org

 **Baldwin**
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Gina Curcio

Assistant Director of Health, Wellness and Community Relations, PreK-12

Phone: 516-434-6081 ♦ FAX 516-434-6821

Enero 2020

Estimado(s) Padre(s)/ guardián(es)

Como saben, la salud y la seguridad de sus hijos son de suma importancia para nosotros. Tomando esto en cuenta, solicitamos su cooperación y atención cuidadosa al siguiente asunto.

Numerosos estudiantes de nuestra escuela son **severamente alérgicos** a alimentos específicos, como leche, huevos, maní y productos de nueces. Puede ocurrir una reacción si se comen y simplemente tocándolos. Esta reacción alérgica puede ser **POTENCIALMENTE MORTAL**. La evitación estricta es la única forma de prevenir una reacción alérgica.

Solicitamos su cooperación para mantener un ambiente seguro para todos nuestros hijos.

- Si su hijo está en una aula con un estudiante con alergia alimentaria, Le pedimos que evite enviar a su hijo con un bocadillo o almuerzo que pueda contener maní.
- Para celebraciones de cumpleaños, le pedimos que celebre sin comida, según las instrucciones del principal de su escuela.
- No se permiten bolsas de regalos que contengan alimentos, como lo que contienen puede incluir elementos que algunos estudiantes son alérgicos a, creando así una reacción adversa y un peligro para la salud.

Es imperativo si su hijo tiene una alergia, por favor infórmenos inmediatamente. Además, proporcione a nuestra enfermera recetas para cualquier medicamento, incluso los de venta libre.

Sólo creando una asociación entre el hogar y la escuela podremos garantizar la salud y la seguridad de nuestros niños.

Gracias por su comprensión y cooperación en este asunto tan importante. Podemos contar con cada uno de ustedes para ayudar a mantener un ambiente seguro para todos nuestros estudiantes.

Si tiene alguna pregunta o preocupación, no dude en ponerse en contacto con la oficina de salud.

Sinceramente,

Gina Curcio

Assistant Director of Health, Wellness and Community Relations, PreK-12

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**BALDWIN UNION FREE SCHOOL DISTRICT
AUTHORIZATION OF MEDICATION ADMINISTRATION IN SCHOOL**

Dear Parent/Guardian:

Please complete this form when a prescription or non-prescription medication is required to be administered in school. We will need:

- A written order from your doctor.
- A parent signature authorizing the Health Office to give the medication.

A parent or guardian must deliver the medication to the nurse in the prescription bottle or original store packaging. UNLABELED MEDICATION WILL NOT BE ACCEPTED OR ADMINISTERED. It is the responsibility of the parent or guardian to keep count of the amount of medication sent into the school.

PHYSICIAN ORDER

NAME OF STUDENT: _____ DIAGNOSIS: _____

MEDICATION: _____ DOSAGE: _____ FREQUENCY: _____

SELF DIRECTED AND/OR MAY ADMINISTER OWN MEDICATION ON SCHOOL TRIPS: YES _____ NO _____

MD SIGNATURE: _____ DATE: _____ PHYSICIAN STAMP: _____

PARENT GUARDIAN CONSENT:

Check the appropriate box(es) below:

- ☐ Please administer the above-mentioned medication as per physician's order.
- ☐ Please allow my child to self-administer his/her own medication on class trip.
- ☐ Please allow my child to carry his/her INHALER/EPI PEN. He or she has been instructed on usage and understands the purpose, method and frequency for this medication.

Parent/Guardian Name: _____ Signature: _____ Date: _____

PLEASE NOTE

Students are only allowed to carry inhalers and/or EpiPens while in school. All other medications need to be stored in the Health Office.

*****This information must be updated annually*****



Baldwin Union Free School District
Anaphylaxis Emergency Action Plan

Patient Name _____ Age: _____

Allergies: _____

Asthma: ☐ Yes (high risk for severe reaction) ☐ No

Additional health problems besides anaphylaxis: _____

Concurrent Medications: _____

Symptoms of Anaphylaxis

MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath
HEART*	weak pulse, dizziness, passing out

Only a few symptoms may be present Severity of symptoms can change quickly.

*Some symptoms can be life-threatening. ACT FAST!

Emergency Actions Steps – Do NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):
- | | |
|--|---|
| ☐ Adrenaclick (0.15 mg) | ☐ Adrenaclick (0.3 mg) |
| ☐ Auvi-Q (0.15 mg) | ☐ Auvi-Q (0.3 mg) |
| ☐ EpiPen Jr (0.15mg) | ☐ EpiPen (0.3 mg) |

Epinephrine Injection, USP Auto-injector-authorized generic

- | | |
|--|-----------------------------------|
| ☐ (0.15 mg) | ☐ (0.3 mg) |
| ☐ Other (0.15 mg) | ☐ (0.3 mg) |

Specify others: Administer EpiPen after 10 minutes if patient is still symptomatic.

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: Home _____ Work _____ Cell _____
Emergency contact #2: Home _____ Work _____ Cell _____
Emergency contact #3: Home _____ Work _____ Cell _____

Comments: _____

Doctor's Signature/Date/Phone Number

Parent's Signature (for individuals under age 18 yrs.) Date

**BALDWIN UNION FREE SCHOOL DISTRICT
AUTHORIZATION OF MEDICATION ADMINISTRATION IN SCHOOL**

Dear Parent/Guardian:

Please complete this form when a prescription or non-prescription medication is required to be administered in school. We will need:

- A written order from your doctor.
- A parent signature authorizing the Health Office to give the medication.

A parent or guardian must deliver the medication to the nurse in the prescription bottle or original store packaging. UNLABELED MEDICATION WILL NOT BE ACCEPTED OR ADMINISTERED. It is the responsibility of the parent or guardian to keep count of the amount of medication sent into the school.

PHYSICIAN ORDER

NAME OF STUDENT: _____ DIAGNOSIS: _____

MEDICATION: _____ DOSAGE: _____ FREQUENCY: _____

SELF DIRECTED AND/OR MAY ADMINISTER OWN MEDICATION ON SCHOOL TRIPS: YES _____ NO _____

MD SIGNATURE: _____ DATE: _____ PHYSICIAN STAMP: _____

PARENT GUARDIAN CONSENT:

Check the appropriate box(es) below:

- ☐ Please administer the above-mentioned medication as per physician's order.
- ☐ Please allow my child to self-administer his/her own medication on class trip.
- ☐ Please allow my child to carry his/her INHALER/EPI PEN. He or she has been instructed on usage and understands the purpose, method and frequency for this medication.

Parent/Guardian Name: _____ Signature: _____ Date: _____

PLEASE NOTE

Students are only allowed to carry inhalers and/or EpiPens while in school. All other medications need to be stored in the Health Office.

*****This information must be updated annually*****

**BALDWIN UNION FREE SCHOOL DISTRICT
BALDWIN, NY**

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental health examination in the following grades: school entry, K, 1, 3, 5, 7, 9, & 11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's 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

I. The dental health condition of _____ on _____ (date of exam) The date of the exam 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 name and address

(please print or stamp)

Dentist'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 1/2 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.