



EDGEMONT JR/SR. HIGH SCHOOL HEALTH OFFICE

200 White Oak Lane

Scarsdale, NY 10583

(914) 725-6175 FAX: (914) 725-4032

klacerra@edgemont.org

Dear Parents/Guardians:

Please use this packet of forms for your rising **8th**, **10th**, and **12th** grade student(s). If your child participates in interscholastic sports, their physical exam expires one year from the date of their last examination.

In this packet you will find:

1. **Annual Health and Sports Exam Form:** (required for both sports participation, and state health exam mandate): In accordance with New York State Education Law, your physician must complete, sign and date this form. No other forms will be accepted.
2. **Medication Authorization Form:** To comply with New York State Education Law, this form must be completed by both a physician and parent prior to administering any medication or treatment to your child during school hours. This is required for any prescription medication or non prescription (OTC) medications/treatments. All medications must be delivered by a parent to an authorized school official, in the original container labeled with the child's name.

For Epipens, inhalers, or diabetic medications, please contact the nurse directly.

All forms are available on the EHS website under the school info tab.

For sports registration and information:

Please contact the Athletic Director's office at (914) 725-1500 ext 1592/1570. Further information can be found on the Athletic page on the EHS website.

Absences must be reported to the Attendance Clerk by 9am:

Email: attendance@edgemont.org

Phone: (914)725-1543

Please feel free to contact the health office with any questions or concerns.

Sincerely,

The Health Office Team

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: ☐ 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 $\geq 5 \mu\text{g/dL}$
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*
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☐ 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 Screening	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐
Notes					
Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail	Referral ☐ Yes		☐
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐ Yes	☐
FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK					
☐ *Family cardiac history reviewed – required for Dominick 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 <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: ☐ I ☐ II ☐ III ☐ IV ☐ V					
☐ Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
*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.					



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200 White Oak Lane

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(914) 725-6175 • FAX: (914) 725-4032

In order to comply with **New York State Education Law**, the following steps must be taken if your child requires either prescription or over the counter medication during the school day:

- **Required Authorizations:** The school nurse must receive a signed Medication Authorization Form (see attached) signed by both a parent/guardian and the student's physician.
- **Medication Drop-Off/Pick-Up:** An adult (preferably a parent/guardian) must deliver or pick up a student's medication to/from the school nurse. Students are not allowed to transport medications.
- **Packaging Requirements:**
 - Prescriptions: Must be in the original pharmacy container labeled with the student's name, medication name, dosage, and usage instructions.
 - OTC Medications: Must be factory-sealed with the student's name written on the package.
 - All labeled medications are stored securely in the health office.
- **Supply Limits:** Please only provide the specific amount of medication needed during school hours.
- **Stocked Items:** The health office routinely stocks only Ibuprofen, Acetaminophen, and Diphenhydramine. Parents must supply all other OTC medications.
- **Medications for Self-Carry:** Students are strictly prohibited from carrying any medication at school. The only exceptions are **Inhalers** and **EpiPens**, which require independent carry permission from a physician. The self carry option can be found on the Asthma Action and/or FARE forms (both available on our website).

Please do not hesitate to contact the health office with any questions or concerns you may have. Karen Lacerra, RN BSN can be reached at (914) 725-6175 or by email at: klacerra@edgemont.org

Sincerely,

The Health Office Team

Medication Authorization Form

Edgemont Jr./Sr. High School Health Office
914-725-6175

Student's Name: _____ **DOB:** _____ **Allergies:** _____ **Grade:** _____

For both prescription and over the counter (OTC) medications given in school, the New York State Education Department requires prior written approval from **both** a healthcare provider and the parent/guardian. If your child requires any OTC medication, both your health care provider and you will need to complete this form and supply the OTC medication for your child. There are certain common OTC products listed below that will need physician and parent consent. Once completed, this form allows the school nurse to administer or apply the following OTC medications (from the health office stock supply) listed below to your child during school hours.

Medication	Indications	Instructions: (circle the dose allowed) Dosage/Route		Frequency	Health Care Provider Consent (Initial	Parent/ Guardian Consent (Initial)
Tylenol (Acetaminophen) Tabs	Pain or fever >100.4	325mg 650mg	By Mouth	Every 4 hours as needed		
Advil (Ibuprofen) Tablets	Pain or fever >100.4	200mg 400mg	By Mouth	Every 6 hours as needed		
Benadry (Diphenhydramine Hydrochloride) caps/tabs	Allergic reactions/hives	25mg 50mg	By Mouth	Every 4 hours as needed		
TUMS Chewables	Indigestion/Upset stomach	500mg 1000mg	By Mouth	Every 6 hours as needed		
Hand/bod / lotion: (Unscented) Eucerin or similar brand	Dry, itchy skin	Topical application to site				
Calamine lotion	Analgesic Anti-antipruritic	Topical application to site				
Alcohol liquid 70% & Alcohol prep pads	Skin protectant/ Antiseptic	Topical application to site				
Antibacterial: Benzalkonium	Antibacterial: First Aid	Topical application to site				
Aquaphor (Petrolatum)	Apply to dry and/or irritated/skin/lips	Topical application to site				
Purified water	Eyewash/Ophthalmic	Irrigation of eyes				
Contact Eye Solution: Bausch and Lomb or similar brand	Ophthalmic	For contact insertion				
Sting Relief swabs/ pads containing Ethyl alcohol/ Benzocaine 6%	Antiseptic and Analgesic	Topical application to site				
Burn Spray (Lidocaine HCL 2%)	Analgesic: For minor burns	Topical application to site				
Please indicate below any daily meds, prescription meds, or other OTC meds to be administered (provided by parent)						

To be completed by Health Care Provider:

I authorize the medications I have initialed above to be administered to this student

Name/Title of Licensed Prescriber: (please print)	License #:	Date:
*Signature:	Initials:	Phone:

To be completed by Parent/Guardian:

Name: (please print)	Date:
*Signature:	Initials:

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): _____

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.