

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
Joseph Delgado - President
Corinne Hammons - Vice President

Board Trustees
Marilyn Adsitt
Frank Caliguiri
Laura Cangemi
Marie Davis
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 2026-27 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 July 30. 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.

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
Joseph Delgado - President
Corinne Hammons - Vice President

Board Trustees
Marilyn Adsit
Frank Caliguiri
Laura Cangemi
Marie Davis
Steven D. Gellar
Nancy H. Hancock
Dr. Bridgette Waite

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)

Current Medications:	Times per day	When taken
----------------------	---------------	------------

_____		_____
_____		_____

Allergies (list):	Reaction
_____	_____
_____	_____

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 _____

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
Joseph Delgado - President
Corinne Hammons - Vice President

Board Trustees
Marilyn Adsett
Frank Caligiuri
Laura Cangemi
Marie Davis
Steven D. Gellar
Nancy H. Hancock
Dr. Bridgette Waire

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: ☐ M ☐ 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/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th 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 ☐ ☐ One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
 Sickle Cell Screen/PRN ☐ ☐ ☐ Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K **Date** ☐ Mental Health: _____
☐ Test Done ☐ Lead Elevated ≥ 10 $\mu\text{g}/\text{dL}$ ☐ Other: _____

☐ System Review and Exam Entirely Normal

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

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

☐ Assessment/Abnormalities Noted/Recommendations: _____ Diagnoses/Problems (list) _____ ICD-10 Code _____

☐ Additional Information Attached

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

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
Joseph Delgado - President
Corinne Hammons - Vice President

Board Trustees
Marilyn Adsitt
Frank Caliguiri
Laura Congemi
Marie Davis
Steven D. Gellar
Nancy H. Hancock
Dr. Bridgette Waite

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.

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
Joseph Deigado - President
Corinne Hammons - Vice President

Board Trustees
Marilyn Adsitt
Frank Caligiuri
Laura Cangemi
Marie Davis
Steven D. Gellar
Nancy H. Hancock
Dr. Bridgette Waite

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 _____

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
Joseph Delgado - President
Corinne Hammons - Vice President

Board Trustees
Marilyn Adsitt
Frank Caliguiri
Laura Cangemi
Marie Davis
Steven D. Gellar
Nancy H. Hancock
Dr. Bridgette Waite

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 _____