MAMARONECK UNION FREE
SCHOOL DISTRICT
Mamaroneck, NY 10543

New Students

Dear Parents/ Guardians of New Students:

Please complete the following forms in the enclosed packet:



1. **Physical Examination Certificate:** to be completed by a **New York State physician/ practitioner** after having a physical examination.

By law, all new students and those entering grades pre-kindergarten, kindergarten, first, third, fifth, seventh, ninth and eleventh must have a NYS physical examination. Completed forms signed, stamped and dated within the last 12 months are acceptable.

2. **Vaccination Administration Form:** to be completed by your child's physician/ practitioner.

3. **Tuberculin Screening Form:** to be completed by your child's physician/practitioner.

4. **Body Mass Index Form (BMI):** (form not included in packet)

The School Nurse must submit a BMI and Weight Status Category report on students needing physical exams. Should you choose NOT to want your child's anonymous data reported to the State, please go to our website and print out the BMI Refusal Form, sign it and return it to your School Nurse as soon as possible.

5. **Child Health History Information Form:** to be completed by the parent/ guardian.

The information on this form helps ascertain the current health status of your child. This form is to be completed annually.

6. **Dental Examination Certificate:** to be completed by your child's dentist.

New York State requires public schools to request a dental health certificate for students at the time of school entry and in grades pre-kindergarten, kindergarten, first, third, fifth, seventh, ninth and eleventh.

7. **Medication Permission Form:** to be completed and signed by your child's physician/ practitioner and signed by a parent/ guardian, only if your child will be taking any medication while he or she is at school during the school day.

This form is NOT included in your packet. If needed, please pick one up at the Health Office or print it from the school website.

No student may bring in or take any medication in school (including inhalers) without a completed Medication Permission Form as well as a pharmacy labeled container for the medicine. This includes ALL medicines such as Tylenol or Motrin etc. All medications are kept locked in the nurse's office.

If your child has asthma, it is recommended to keep an extra inhaler at the nurse's office.

You may upload your Health documents in School Status Forms & Flows or email the documents directly to your school nurse. The nurses email information can be located on the Mamaroneck school website under Department- Health Services- Health Service Staff.

PLEASE DO NOT MAIL FORMS TO YOUR SCHOOL DURING THE SUMMER MONTHS.

NEW STUDENTS MAY NOT BEGIN SCHOOL WITHOUT BEING MEDICALLY CLEARED BY THE BUILDING NURSE.

If you have any questions, please call the Health Office. Thank you for your cooperation.

Sincerely,

Central School Nurse– 914-220-3410
Chatsworth School Nurse– 914-220-3510
Mamaroneck Ave School Nurse – 914-220-3610/3618
Murray School Nurse– 914-220-3710
Hommocks School Nurse– 914-220-3310/3318
Mamaroneck High School Nurse – 914-220-3111/3312

All forms are available online at www.mamkschools.org

Departments › Health Services › Health Information and Provider Forms › Registration Health Packet Forms

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**	Type: ☐ 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 Type: ☐ 2	
	☐ Medication/Treatment Ordered Attached	☐ Diabetes Medical Management Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History 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 ☐ No ☐ 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	Date
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 µg/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 New Entrants, 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/	☐ Yes	☐
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 Required for Boys grade 9 and Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐	☐

Notes:

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ **Family cardiac history reviewed** – required for sports (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, or Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, or Volleyball
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.
- ☐ **Other Restrictions:**

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the 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: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

MAMARONECK UNION FREE SCHOOL DISTRICT
VACCINATION ADMINISTRATION RECORD

Please return this report to your **School Nurse** as soon as your child's vaccinations have been given and/or updated. Failure to provide acceptable evidence of immunizations within fourteen days of entry may lead to exclusion from school. This period may be extended up to thirty days for those transferring from out of state or abroad. Vaccines must follow the Advisory Committee for Immunization (ACIP) guidelines.

This form should be completed and/or updated annually. Please see the list of immunization requirements below:

NAME: _____ **DATE:** _____

DOB: _____ **GRADE:** _____ **TEACHER/COUNSELOR** _____

School: ○ CEN ○ CHAT ○ MAS ○ MUR ○ HMX ○ HS ○ Other: _____

Immunization Requirements:

As required by NY State Dept. of Education, Health Care Provider verification of the following is needed for school attendance:

- **DTaP : three - five (3-5) doses** of diphtheria and tetanus toxoid-containing vaccine and acellular pertussis vaccine
- **Tdap : one (1)dose** - students 11 years of age or older entering grade 6 through 12 are required to have one dose of Tdap
- **IPV : three – four (3-4) doses** of polio vaccine
- **MMR : two (2) doses** of live measles, mumps and rubella vaccine (K-12)
- **Hepatitis B: three (3) doses** of Hepatitis B vaccine at intervals recommended by the ACIP
- **VARICELLA: – two (2) doses** of Varicella (chicken Pox) entering kindergarten through Grade12
- **MENINGOCOCCAL: one (1) dose** entering Grade 7 through 11, one-**two (1-2) doses** at age 16 and entering Grade 12

In addition, for pre-kindergartners:

- **Hib** Haemophilus influenzae type b vaccine: 1-4 doses
- **PCV** Pneumococcal conjugate (**PCV**) 1-4 doses (age appropriate)
- **MMR & Varicella :** one (1)dose

VACCINATION ADMINISTRATION RECORD
TO BE COMPLETED & SIGNED BY THE HEALTH CARE PROVIDER

VACCINE DATE GIVEN:

DTaP 1 _____ DTaP 3 _____

DTaP 2 _____ DTaP 4 _____

DTaP 5 _____ OR...

DT 1 _____ OR Td 1 _____

DT 2 _____ OR Td 2 _____

DT 3 _____ OR Td 3 _____

Tdap _____

IPV 1 _____ IPV 3 _____

IPV 2 _____ IPV 4 _____

VARICELLA 1 _____

VARICELLA 2 _____

MMR 1 _____

MMR 2 _____

TST (LAST) MANTOUX _____ RESULT _____ ❖

BCG _____

❖ If Positive TST, Chest x-ray needed:
Date of CXR: _____ Results: _____

VACCINE DATE GIVEN:

HEP B 1 _____

HEP B 2 _____

HEP B 3 _____

OR (Adult formulation 2 dose series, ages 11 – 15 yrs)

HEP B 1 (1.0 ML) _____

HEP B 2 (1.0 ML) _____

HIB 1 _____

HIB 2 _____

HIB 3 _____

HIB 4 _____

PNEUMOCOCCAL VACCINE

1 _____ 2 _____ 3 _____ 4 _____

MENINGOCOCCAL VACCINE _____

MENINGOCOCCAL VACCINE _____

HEP A 1 _____ HEP A 2 _____

HUMAN PAPILLOMAVIRUS VACCINE (HPV)

1 _____ 2 _____ 3 _____

COVID _____

Other _____

OFFICE STAMP NECESSARY HERE ↓

Healthcare Provider

NAME (Print) _____ SIGNATURE: _____

ADDRESS: _____ TELEPHONE #: _____

CITY/STATE/ZIP: _____ DATE: _____

MAMARONECK UNION FREE SCHOOL DISTRICT

HEALTH OFFICE

Tuberculosis Screening/Clearance

Student's Name _____

Mamaroneck Schools require TB risk assessment for all incoming new students.

Students with **NO RISK FACTORS** do not require further testing.

_____ This student has no TB risk factors

MD SIGNATURE HERE_____

DATE_____ STAMP_____

Students with Risk Factors require TB testing:

_____ History of TB exposure

_____ Immigration from high incidence countries (Asia, Africa, Eastern Europe, Central & South America)

_____ Lodging with local residents, families in high incidence countries during travel

_____ Household contact with family members from high incidence countries

_____ Exposure to HIV infected, homeless, drug using or incarcerated individuals

_____ **TUBERCULIN SKIN TEST (TST)**

Date Placed_____ Date Read_____

mm of Induration_____

_____ Chest X-ray results

MD SIGNATURE HERE _____

DATE_____ STAMP_____

Please see over for helpful information

These countries have LOW RATES OF TB. (2014 WHO)

Australia, Austria, Bahamas, Belgium, Canada, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Luxembourg, Malta, Netherlands, New Zealand, Norway, Puerto Rico, Slovakia, Slovenia, Sweden, Switzerland, United Arab Emirates, United States of America. West Bank and Gaza Strip.

All other countries not listed have high rates of TB exposure (and require testing)

If Tuberculin Test or IGRA is positive, now or previously, the following are required:

1. **Date of Positive TST or IGRA** **Date:** _____/ _____/ _____

2. **Chest X-ray: (Please attach copy of report)** **Date:** _____/ _____/ _____

   _____ **Normal**

   _____ **Abnormal** _____
   (Describe)

3. **Clinical Evaluation:**
   _____ **Normal**

   _____ **Abnormal** _____
   (Describe)

4. **Treatment:**
   _____ **No** _____
   (Please explain)

   _____ **Yes** _____
   (Drug, Dose, Frequency, Dates)

Additional review of history, if indicated:

- BCG Vaccine _____date
- Previous POS TST_____ date
- Previous treatment_____date

Any other comments _____

Thank you.

Mamaroneck Union Free School District

STUDENT MEDICAL HISTORY INFORMATION

(To be completed by Parent or Guardian at the beginning of each school year)

Your student's learning depends upon good health. To assist in providing health services at school, please complete the following form. Information is confidential and may be shared with teaching staff as needed. **Return this form to the school nurse as soon as possible.** Thank you.

Student's Name: (Please print) _____ **Date of birth:** _____ **Male☐ Female☐**

Grade:_____ **Teacher/Counselor:** _____

School: ☐ Central ☐Chatsworth ☐Mamaroneck Avenue ☐Murray
☐Hommocks ☐High School ☐ Other

Resides with Parent/Guardian Name(s): _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Siblings/Other: (Name)_____; ☐Male ☐Female; DOB_____; relationship: _____

Doctor's name: _____ Date of last physical: _____
Dentist's name: _____ Date of last visit: _____

Is the student under an orthodontist's care? ☐No ☐Yes **Doctor's Name**_____

Birth history: Any complications or problems during pregnancy and/or delivery? ☐No ☐Yes
Please describe: _____
Full term birth? ☐No ☐Yes If no, how premature was the child? ____(weeks). Birth weight: _____lbs. _____oz.

Has the student ever had:	YES	Date:		YES	Date:
Chicken Pox	☐	_____	Meningitis	☐	_____
Encephalitis	☐	_____	Rheumatic Fever	☐	_____
Lyme disease	☐	_____	Positive TB test	☐	_____
Bleeding tendency	☐	_____	Pneumonia	☐	_____
High Blood Pressure	☐	_____	Kidney disease	☐	_____

Any complications from above illnesses? (please explain) _____

Does the student have or had a history of the following?

- Allergies? Yes ☐
  To drugs, food, insects, pollen? Please list:_____
  Has the allergy required emergency action in the past? No☐ Yes☐
  What happens to the student? _____
- Asthma? Yes ☐
  Triggered by: _____Treatment: _____
  Diagnosed by doctor? _____Date:_____
  Uses: inhaler☐ nebulizer☐ other medication☐
  Taken: at home only☐ may need medication at school☐
- Attention Deficit Disorder Yes ☐
  Is the student currently taking medication? No☐ Yes☐
  Name of medication:_____ Dose (mg):_____
  How often does he/she take it? _____

OVER PLEASE

• Bee sting allergy Yes ☐ Describe reaction: _____
Difficulty breathing No☐ Yes☐
Need emergency medication? No☐ Yes☐

• Bone, joint problems or broken bones? Yes ☐ Describe: _____
Any physical restrictions? _____

• Diabetes Yes ☐ Requires insulin? No☐ Yes☐ Date Diagnosed: _____

• Dizziness, loss of consciousness, fainting or loss of memory? Yes☐

• Heart condition, murmur, or irregular heart beat? Yes ☐ Describe: _____
Any physical restriction? No☐ Yes☐
What are they? _____ Medication? No☐ Yes☐

• Past history of increased lead levels in the blood? Yes ☐ When? _____ What was the level? _____

• Loss of an eye, kidney, testicle or other organ? Yes ☐ _____

• Previous head injury? Yes ☐ Age: _____ Describe: _____

• Seizures? Yes ☐ Type of seizure: _____
Date of last seizure: _____ Medication: _____
Is the student currently under s a doctor's care for seizure?
No☐ Yes☐

Has the student had any other illness? _____
Does the student take other daily medication at home? No ☐ Yes ☐ **At school?** No ☐ Yes ☐
Name of medication: _____ Reason for taking it: _____
Has the student had any condition which required emergency treatment or hospitalization? No ☐ Yes ☐

If yes, for what?	Age	How long in hospital?	Surgeries?
_____	____	_____	_____

Check off the following health categories/concerns that pertain to the student?
<> Eyes: ☐wears glasses ☐wears contacts: ☐for reading ☐for distance ☐all the time
<> Ears: ☐frequent infections ☐ear tubes present Date: _____
wears hearing aid; ☐ right ear ☐left ear ☐ hearing difficulty: explain: _____
<> Other: ☐nosebleeds ☐requires diapering ☐sleeping difficulties ☐eating too little
☐headaches/migraines ☐requires catheterization ☐dental concerns ☐eating too much
☐bowel ☐bladder ☐bed wetting ☐menstruation ☐phobias

Does the student have any medical, physical, learning, or emotional problems that the school should know about?
(handicaps; parents recently separated; etc.) _____

Has your student been evaluated by any of the following professionals? (in the last 12 months):

☐audiologist ☐occupational therapist ☐psychologist ☐speech/language therapist
☐neurologist ☐physical therapist ☐psychiatrist ☐other: _____

Please list any other health concerns you have for the student. _____

_____
Parent/ Guardian signature Date

MAMARONECK UNION FREE SCHOOL DISTRICT

Mamaroneck, NY 10543

DENTIST CERTIFICATE

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Name:_____ **Date of Birth:**_____

Home Address:_____

School:_____ **Grade Level:**_____ **Teacher:**_____

TO BE COMPLETED BY DENTIST:

Date of Last Examination:_____

Check work that was completed at the last examination:

__Inspection __Cleaning __Repair __No Treatment

Please provide any information about the child's dental health that the school nurse should be aware of:

_____

_____

_____

_____

_____

Name of Dentist (please print):_____ **Phone:**_____

Signature:_____ **Date:**_____

Dentist Office Stamp (required):