



Important Information from the Nurse's Office 2019-2020 School Year

*Please fill out and return the attached HIPPA and Health Form, if applicable

- **New Students** need to have in place for the beginning of the school year:

1. A current physical (less than 12 months old)
2. An immunization record that is up to date for their grade level (see back of this sheet)
3. Any allergy information is extremely urgent for us to have in place before the first day of school

- **Returning students entering Kindergarten, 1st, 3rd, and 5th grade** need to have:

1. A physical just before or during the school year
2. Immunizations as required for their grade level (see back of this sheet)

- **Students entering 6th grade (age 11 or older)** need to have:

1. The Tdap (Tetanus, Diphtheria, & Pertussis) booster vaccine.
2. Second dose of Varicella

- **Students entering Kindergarten** need to have:

1. Two doses of MMR (Measles, Mumps, Rubella)
2. Two doses of Varicella vaccine
3. Four doses of Polio vaccine (unless the 3rd dose was received at age 4 or older)
4. Five doses or 4 doses of Diphtheria, Tetanus, and Pertussis (DTaP/DTD/Tdap/TD)

*A parent's report of disease does not prove immunity. The proof may be one of the following; A blood test report that proves the student is immune to the disease (blood titer) or A note from the doctor saying the child has had the disease.

Please be sure your child gets these immunizations before the start of school and bring proof of immunizations to the school nurse.

Religious or medical exemptions must be requested in writing to the school principal and approved before the first day of school.

Immunizations can be given by your own doctor or received from the Monroe County Health Department. Please call for walk-in hours.

Monroe County Health Department
111 Westfall Rd.
Immunization Clinic 585-753-5150
(for PPD) Tuberculosis Clinic 585-753-5161

*****Any child with medications (EPI-pens, inhalers, etc.)** need to have:

1. New medications, with dates of July, August, or beginning of September 2018 only
2. New doctor orders for medications that are to be administered during school hours
3. Medication and doctor orders brought into school by Parent/Guardian on Thursday, August 30 (PK/Kdg Orientation), Tuesday, September 4 (Meet the Teacher Day), or Wednesday, September 5 (First Day of School)

This is mandated by RCSD who oversees our Nursing Department.

Thank you for your cooperation in this very important matter.

Sr. Mary Jo Flynn, SSJ, LPN

Karon Hess, RN

2019-20 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades pre-k through 11, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grade 12 except for interval between measles vaccine doses. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements **MUST** be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses If the 4th dose was received at 4 years or older or 3 doses If 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap) ²	Not applicable		1 dose	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses If the 3rd dose was received at 4 years or older	4 doses or 3 doses if the 3rd dose was received at 4 years or older	3 doses
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		1 dose
Meningococcal conjugate vaccine (MenACWY) ⁸	Not applicable		Grades 7, 8, 9 and 10: 1 dose	2 doses or 1 dose If the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		



Authorization for Use or Disclosure of Health Information (HIPAA)

Student Name _____ Birthdate: _____

Healthcare provider (doctor) _____ Phone: _____

Address _____ Fax: _____

Healthcare provider (doctor) _____ Phone: _____

Address _____ Fax: _____

Monroe County Health Dept. Clinics

Lead Testing **TB Clinic** **Immunization Clinic** **Other** _____

I hereby authorize my/my child's physician(s) listed above to exchange the following information with Rochester City School District, including:

All

Or Specified:

- | | |
|---|--|
| <input type="checkbox"/> School nurse | <input type="checkbox"/> Immunizations to comply with NYS regulations |
| <input type="checkbox"/> Medical officer | <input type="checkbox"/> Physical exams to comply with NYS regulations and sports requirements |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Authorization for medications during the school day or on school trips |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Medical clearances as needed following an injury or change in condition |
| <input type="checkbox"/> Speech Therapist | <input type="checkbox"/> Medical orders required for therapy needs, evaluations |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Physician referral for services (OT, PT) |
| <input type="checkbox"/> Vision Department | <input type="checkbox"/> Medical condition/ treatment plans that may have an impact in school |
| <input type="checkbox"/> Special Education | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | |

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon signing this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. Positive results on lead testing are shared on a need to know basis between the health services and the educational team to develop suitable programming to address any problems associated with high lead levels.

This release expires on the last day of the enrollment of the above student in the Rochester City School District, and may be revoked at any time by sending a written and signed request to cancel this permission to the address above. Such revocation will not affect any disclosure made prior to its receipt by the District. Protected health information will not be disclosed without consent pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and implementing regulations (34 C.R.F. § 99). **A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the Rochester City School District by the healthcare providers listed above.**

(Signature of Parent/Guardian)**

(Date)

If student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, state authority to act on student's behalf: _____. If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act and the information requested pertains thereto, then the parent/guardian must also sign consent form.

Return completed form to the NURSE at the school this child attends.

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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School: Nazareth Elementary School – Fax # 585-647-8717	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other :	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type:	Date of last seizure:

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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-99th 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	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 µg/dL				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

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

<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	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<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		

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain <input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator* <input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain:				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached	<input type="checkbox"/> Reported in NYSIS	Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> 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.				