Important Information from the Nurse's Office
2021-2022 School Year

Please completely fill out and return the attached Authorization for Use or Disclosure of Health Information (HIPPA) form, and take the School Health Examination form to your pediatrician to complete if a new physical exam is required for your student this year. (Pediatricians may use their own forms if they are similar.)

- ***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. Allergy information – this is extremely urgent for us to have in place before the first day of school
- ***Returning students entering Kindergarten, First, Third, and Fifth Grade*** need to have:
  1. A physical just before or during the school year
  2. Immunizations as required for their grade level (see next page)
- ***Students entering SixthGrade (age 11 or older)*** need to have:
  1. The Tdap (Tetanus, Diphtheria, and Pertussis) booster vaccine
  2. Second dose of Varicella vaccine
- ***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 third dose was received at age four or older)
  4. Five doses or four 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.

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

1. New medications, with dates of July, August, or beginning of September 2021 only
2. New doctor orders for medications that are to be administered during school hours
3. Medication in original box with RX and doctor orders brought into school by Parent/Guardian on Preschool/Kindergarten Orientation Day, Meet the Teacher Day, or the first day of school.

This is mandated by the Rochester City School District who oversees our Nursing Department.

Thank you for your cooperation in this very important matter.
Sr. Marlene Pape, SSJ, RN
Karon Hess, RN

2021-22 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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). 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. 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 adolescent booster (Tdap)[3]	**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		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**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**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 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**		

NEW YORK STATE | Department of Health

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 Nazareth Elementary School, including:

☐ **All**

or specified:

☐ School nurse
☐ Medical officer
☐ Physical Therapist
☐ Occupational Therapist
☐ Speech Therapist
☐ Audiologist
☐ Vision Department
☐ Special Education
☐ Other _____

☐ Immunizations to comply with NYS regulations
☐ Physical exams to comply with NYS regulations and sports requirements
☐ Authorization for medications during the school day or on school trips
☐ Medical clearances as needed following an injury or change in condition
☐ Medical orders required for therapy needs, evaluations
☐ Physician referral for services (OT, PT)
☐ Medical condition/ treatment plans that may have an impact in school
☐ 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 at Nazareth Elementary School 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 school. 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 Nazareth Elementary 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 Nazareth Elementary.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School: Nazareth Elementary School – Fax #585.647.8717	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
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 ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.