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 printout 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 Sheet: 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 Sheet** as well as a pharmacy labeled container for the medicine. This includes ALL medicines such as Tylenol, Motrin, cough syrup, 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.

   Please return all forms to the Health Office as soon as they are completed. Make sure to keep a copy of the forms for yourself.

   PLEASE DO NOT MAIL FORMS DURING THE SUMMER MONTHS. YOU CAN BRING THEM IN UNITL THE END OF JUNE WHILE SCHOOL IS IN SESSION OR BRING THEM IN THE FIRST WEEK OF SCHOOL. PLEASE HAND THEM DIRECTLY TO THE SCHOOL NURSE.

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

Sincerely,

Vicky Ruggiero RN –Central School - 914-220-3410
Karen Torre RN – Chatsworth School – 914-220-3510
Madeline Lukas RN – Mam'k Ave School – 914-220-3610
Bonnie Ball RN – Murray School – 914-220-3710
Jacqueline Sheppard RN – Hommocks School – 914- 220-3310
Maureen Crean RN – MHS – 914-220- 3112
Dina Murphy RN – MHS -914-220-3111

ALL FORMS ARE AVAILABLE ON LINE AT WWW.MAMKSCHOOLS.ORG- COMMUNITY- HEALTH SERVICES-RESOURCES - HEALTH FORMS/REGISTRATION PACKET AND HEALTH INFORMATION FOR PARENTS

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
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ 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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ 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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ 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 NYSIIS 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.

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. Obtaining proper vaccinations for your child is required by law and admission to school can be **denied** without them. 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)
- **HBV : three (3) doses** of Hepatitis B vaccine at intervals recommended by the ACIP
- **VARICELLA: – two (2) doses** of Varicella (chicken Pox) entering kindergarten, Grade 1, 2, 3, 4, 6,7, 8, 9 & 10
- **MENINGOCOCCAL: one (1) dose** entering Grade 7,8 & 9 **one-two (1-2) doses** at age 16, entering Grade 12

In addition, for pre-kindergartners:

- **Hib** Haemophilis influenzae type b vaccine: 1-4 doses
- **PCV** Pneumococcal conjugate (**PCV**) 1-4 doses (age appropriate)

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: _____
INH started: _____ X _____ months

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 _____

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. (2013)

Albania, America Samoa, Andorra, Antigua and Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, United States Virgin Islands, United States of America

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

CHILD MEDICAL HISTORY INFORMATION

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

Your child'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 form to school nurse as soon as possible.** Thank you.

Child's name: (Please print)_____ **Date of birth:** _____ **Boy** ☐ **Girl** ☐

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

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

Lives at home with:

(Name)_____; Mother (Name)_____; Father

Siblings/Others: (Name)_____; Male ☐ Female ☐ ; date of birth _____; relationship:_____

(Name)_____; Male ☐ Female ☐ ; date of birth _____; relationship:_____

(Name)_____; Male ☐ Female ☐ ; date of birth _____; relationship:_____

(Name)_____; Male ☐ Female ☐ ; date of birth _____; relationship:_____

(Name)_____; Male ☐ Female ☐ ; date of birth _____; relationship:_____

Child Caretaker: (Name) _____ Male ☐ Female ☐ ; relationship:_____

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

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

Is child 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 child? _____ (weeks). Birth weight: _____lbs. _____ oz.

Has this child ever had (a):	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 child have or has child ever had:

- Allergies? Yes ☐
  To drugs, food, insects, pollen? Please list:_____
  Has the allergy required emergency action in the past? No ☐ Yes ☐
  What happens to child? _____
- 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 your child taking medication for this now? 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 or joint problems or broken bones? Yes ☐ Describe: _____
  Any physical restrictions? _____
- Diabetes? Yes ☐ Takes insulin? No ☐ Yes ☐ Date diagnosed: _____
- Dizziness, loss of consciousness, fainting or lost memory?.....Yes ☐
- Heart condition, murmur, or irregular heart beat? Yes ☐ Describe: _____
  Any physical restrictions? 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 ☐ At age: _____ Describe: _____
- Seizures? Yes ☐ Describe seizure: _____
  Date of last seizure: _____ Medication: _____
  Is student currently under a doctor's care for seizure? No ☐ Yes ☐

Has this child had any other illness? _____

Does your child take any other daily medication at home? No ☐ Yes ☐ **At school?** No ☐ Yes ☐
Name of medication: _____ Reason for taking it: _____

Has this child had any condition which required emergency treatment or hospitalization? No ☐ Yes ☐

If yes, for what?	Ate age:	How long in hospital?	Surgeries (operations)?
_____	_____	_____	_____
_____	_____	_____	_____

Check off the following health categories/concerns that pertain to your child:

◇Eyes: wears glasses ☐; wears contacts ☐ : for reading ☐, for distance ☐, all the time ☐; single vision? ☐

◇Ears: frequent infections ☐; ear tubes present ☐, since _____

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	☐ phobias
☐ bowel	☐ bed wetting	☐ eating too much	☐ menstruation
☐ bladder			

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

Does any relative or anyone in the home have tuberculosis, diabetes, or other illness? _____

Describe: _____

Has your child 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 your child: _____

X _____ _____

(Signature of legal parent/guardian) (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):