# MAMARONECK UNION FREE
## SCHOOL DISTRICT
Mamaroneck, NY 10543

*Estudiante nuevo*

Estimados padres/tutores de estudiantes nuevos:

Por favor completen los siguientes formularios en el paquete adjunto:

1. Certificado de examen físico: para ser completado por un **médico/profesional del Estado de Nueva York** después de tener un examen físico.

   Por ley, todos los estudiantes nuevos y aquéllos que ingresan a los grados de pre-Kindergarten, Kindergarten, primero, tercero, quinto, séptimo, noveno y undécimo deben tener un examen físico del Estado de Nueva York. Los formularios completos firmados, sellados y fechados en los últimos 12 meses son aceptables.

2. **Formulario de administración de vacunación**: para ser completado por el médico/profesional de su hijo(a).

3. **Formulario de detección de tuberculina:** debe ser completado por el médico/profesional de su hijo(a).

4. **Formulario del índice de masa corporal (IMC):** (forma no incluida en el paquete)

   La enfermera escolar debe enviar un informe de IMC y categoría de estado de peso a los estudiantes que necesiten exámenes físicos. Si eligen NO querer que los datos anónimos de su hijo sean informados al Estado, visiten nuestro sitio web e impriman el Formulario de rechazo del IMC, fírmenlo y devuélvanlo a su Enfermera escolar lo antes posible.

5. **Formulario de información del historial de salud del niño(a):** para ser completado por el padre/tutor.
   La información en este formulario ayuda a determinar el estado de salud actual de su hijo(a). Este formulario debe completarse anualmente.

6. **Certificado de examen dental:** para ser completado por el dentista de su hijo(a).

   El Estado de Nueva York exige que las escuelas públicas soliciten un certificado de salud dental para los estudiantes al momento de ingresar a la escuela y en los grados de pre-Kindergarten, Kindergarten, primero, tercero, quinto, séptimo, noveno y undécimo.

7. **Hoja de permiso de medicamentos:** debe ser completada y firmada por el médico/profesional de su hijo(a) y firmada por un padre/tutor, sólo si su hijo(a) tomará algún medicamento mientras esté en la escuela durante el día escolar.
   Este formulario NO está incluido en su paquete. Si es necesario, elijan uno en la Oficina de Salud o imprímanlo desde el sitio web de la escuela.

   Ningún estudiante puede traer o tomar ningún medicamento en la escuela (incluidos los inhaladores) sin una Hoja de autorización de medicamentos completa así como un recipiente con la etiqueta de la farmacia para el medicamento. Esto incluye TODOS los medicamentos como Tylenol, Motrin, jarabe para la tos, etc. Todos los medicamentos se guardan encerrados en la enfermería.

   Si su hijo(a) tiene asma, se recomienda tener un inhalador adicional en la enfermería.

   Devuelvan todos los formularios a la Oficina de salud tan pronto como se hayan completado. Asegúrense de guardar una copia de los formularios ustedes mismos

   **NO ENVÍEN FORMULARIOS POR CORREO DURANTE LOS MESES DE VERANO. PUEDEN TRAERLOS EN UNIDADES HASTA FINALES DE JUNIO MIENTRAS LA ESCUELA ESTÁ EN SESIÓN O TRAERLOS EN LA PRIMERA SEMANA DE LA ESCUELA. FAVOR DE ENTREGARLOS DIRECTAMENTE A LA ENFERMERA DE LA ESCUELA.**

   Si tienen alguna pregunta, llamen o pasen por la Oficina de Salud. Gracias por su cooperación.

Sinceramente,

Vicky Ruggiero RN – Escuela Central - 914-220-3410
Karen Torre RN – Escuela Chatsworth – 914-220-3510
Madeline Lukas RN – Escuela Mamaroneck Avenue – 914-220-3610
Bonnie Ball RN – Escuela Murray – 914-220-3710
Jacqueline Sheppard RN – Escuela Media Hommocks – 914- 220-3310
Maureen Crean RN – MHS – 914-220-3112
Dina Murphy RN – MHS - 914-220-3111

TODOS LOS FORMULARIOS ESTÁN DISPONIBLES EN LÍNEA EN 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)

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

| VACCINE | DATE GIVEN: | 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):