

EDGEMONT JUNIOR-SENIOR HIGH SCHOOL
200 WHITE OAK LANE
SCARSDALE, NEW YORK 10583

HEALTH OFFICE

(914)725-1500 ext. 1576
Fax(914)725-4032
mbajorin@mail.edgemont.org



Dear Parents/Guardians:

In accordance with the New York State Education Law, **rising 7th, 9th and 11th graders** are required to have a current physical exam for the beginning of the school year. This includes an exam completed the previous October 2018 or after. Please remember that if your child participates in interscholastic sports their physical expires **1 year** from the date of their last examination.

In the packet you will find:

1. **Annual Health and Sports Exam Form** (*required for both sports participation and state health exam mandate*): In accordance with New York State Education Law, your physician must complete, sign and date this form.
2. **Medication Authorization Form**: In order to comply with New York State Education Law, if it is necessary for your child to take either prescription or any non-prescription (OTC) medications during school hours, this form must be completed by both a parent and physician prior to administration. All medications must be delivered by a parent to an authorized school official, in the original container with the child's name. **NO MEDICATIONS WILL BE DISPENSED WITHOUT THIS.**
3. **Dental Form**: ***(required)** Please complete at most recent appointment within the year.

THESE FORMS ARE ALSO AVAILABLE ON THE EHS WEBSITE

For sports registration and information please call the Athletic Directors office at (914) 725-1500 ext. 1592 or 1570. You can also find information on the EHS website under the Athletics tab.

To report absences call the Attendance Clerk at 725-1543 prior to 9 a.m.

Please feel free to contact me if you have any questions or concerns.

Sincerely,

Mireille Bajorin, R.N.
School Nurse

**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:	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

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"/>
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				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				
<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 NYSIIS		Received Today: <input type="checkbox"/> Yes
HEALTH CARE PROVIDER				
Medical Provider Signature:				Date:
Provider Name: <i>(please print)</i>				Stamp:
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

EDGEMONT JUNIOR-SENIOR HIGH SCHOOL
200 WHITE OAK LANE
SCARSDALE, NEW YORK 10583

HEALTH OFFICE

(914)725-1500 ext. 1576

Fax (914)725-4032

mbajorin@edgemont.org



Dear Parents/Guardians:

In order to comply with New York State Education Law, the following steps must be taken if your child requires either prescription or over-the-counter medication during the school day:

1. The school nurse must have on file a written and signed request from **both** the physician and the parent. The attached form has been provided for your convenience.
2. All medication must be **delivered** to the school nurse **by the parent**. (Advil, Tylenol and Benadryl tablets are the **only** medications stocked in school. Any other medications, including liquid and chewable, must be provided by you.)
3. The medication must be in the **original container**, as it is received from the pharmacist or over-the-counter: **with the child's name, the name of the medication, and a description of the dosage**. Please get a second labeled prescription bottle from your pharmacist and deliver only what will be required during school hours.
4. All medication must be kept in the school nurse's office.
5. Inhalers and EpiPens are the only medications that students may carry, and only if the school nurse has on file a physician's order *and* a self-administration waiver. This form is available upon request.
6. All medications must be picked up by a parent or parent representative. We are not able to allow your students to carry their own medications.

Please do not hesitate to contact Mrs. Bajorin, R.N., our school nurse, for further information and forms.

Sincerely,

Kyle Hosier
Principal

EDGEMONT JUNIOR-SENIOR HIGH SCHOOL
200 WHITE OAK LANE
SCARSDALE, NEW YORK 10583

HEALTH OFFICE
 725-1500 ext.1576
 FAX 725-4032



MEDICATION AUTHORIZATION FORM

Individualized Orders for: _____ D.O.B. _____ Grade _____

Allergies: _____

1. Standard Over-the-Counter/PRN Medications: The following medications are the *only* ones available in health office. For any other medications, see below. These medications will be administered at the discretion of the R.N. per label instruction by age and weight, or as specified by M.D., **only if signed approval is indicated by BOTH the student's physician AND parent.**

Drug Name	Route	<u>DOSAGE</u>	Schedule & Indications	Comments
Tylenol tablets (acetaminophen)	Po	325 mg. 650 mg.	Q4 hr. as needed for pain or fever	
Advil tablets (ibuprofen)	Po	200 mg. 400 mg.	Q6 hr. as needed for pain or fever	
Benadryl capsules (diphenhydramine hydrochloride)	Po	25 mg. 50 mg.	Q4 hr. as needed for allergic reaction, hives	
TUMS	Po	500mg 1 Gm.	PRN as needed for indigestion/upset stomach	

2. PRESCRIPTION and any other Over-the-Counter Medications: PHYSICIAN, please complete with patient's current regimen for both scheduled and PRN medications.

***All prescription medications must be provided directly to the nurse by a responsible adult in the original container with your student's name on it.**

Drug Name	Route	<u>DOSAGE</u>	Schedule & Indications	Comments

Physician Signature: _____ Date: _____

License #: _____ Phone #: _____

**** I authorize the school RN (and on trips, the EMT/ authorized chaperone) to dispense the medication prescribed by the above physician:**

****Parent signature:** _____ **Date:** _____

EDGEMONT JUNIOR-SENIOR HIGH SCHOOL

200 WHITE OAK LANE
SCARSDALE, NEW YORK 10583

HEALTH OFFICE

(914) 725-1500 ext. 1576

Fax (914) 725-4032

mbajorin@edgemont.org



DENTAL FORM

Name of Pupil: _____ Grade: _____

Dear Parents/Guardians:

NYS Education Law (Section 136.3) requires medical and dental examinations of all students entering grades **seven**, **nine** and **eleven** as well as **new students at any grade level**. This is in order to maintain and improve the level of good health.

Please have this form filled out by your family dentist at the time of your child's dental examination. Treatment and correction of any defects found by the dentist, as soon as possible, are the most desirable procedures for any child.

- Patient has been examined and requires no treatment at this time
- Patient is under dental treatment at this time
- Patient has completed all dental treatment

Remarks: _____

Date

Signature of Dentist