

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

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**HEALTH OFFICE**

(914)725-1500 ext. 1576

Fax (914)725-4032

mbajorin@edgemont.org



Dear Parents/Guardians:

Since many students have annual physicals during the spring and summer, I am providing you with forms to be completed by your child's physician. Please remember that if your child participates in interscholastic sports, their physical expires **1 year** from the date of their last exam. You can view the most current date we have on file for your child by logging into your Family ID registration portal.

In this packet you will find:

1. **Annual Health and Sports Exam Form** (*required for sports participation*): In accordance with New York State Education Law, your physician must complete, sign and date this form. **This is the only physical exam that qualifies your child for a sport. No attached form will be accepted unless it is the same NY State form.** (Many physicians' offices use this form now.)
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.**

**THESE FORMS ARE ALSO AVAILABLE ON THE EHS WEBSITE**

**For sports registration and information** please call the Athletics 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: EDGEMONT JR/SR HIGH SCHOOL	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached 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):**  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> 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: _____	
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	<input type="checkbox"/> Mental Health: _____	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$				<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
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:			DOB:	
<b>SCREENINGS</b>				
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>
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				
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys grade 9 And girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
<b>Recommendations:</b>				
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL</b>				
<input type="checkbox"/> <b>Full Activity</b> without restrictions including Physical Education and Athletics. <input type="checkbox"/> <b>Restrictions/Adaptations</b> Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> <b>No Contact Sports</b> <b>Includes:</b> baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> <b>No Non-Contact Sports</b> <b>Includes:</b> archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> <b>Other Restrictions:</b>				
<input type="checkbox"/> <b>Developmental Stage for Athletic Placement Process ONLY</b> Grades 7 & 8 to play at high school level <b>OR</b> Grades 9-12 to play middle school level sports Student is at <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> <b>Accommodations:</b> 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: _____				
<b>MEDICATIONS</b>				
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School attached</b>				
<b>List medications taken at home:</b>				
<b>IMMUNIZATIONS</b>				
<input type="checkbox"/> Record Attached	<input type="checkbox"/> Reported in NYSIIS	Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>HEALTH CARE PROVIDER</b>				
Medical Provider Signature:			<b>Date:</b>	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
<b>Please Return This Form To Your Child’s School When Entirely Completed.</b>				

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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

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**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
<b>Tylenol tablets</b> (acetaminophen)	po	325 mg. 650 mg.	Q4 hr. as needed for pain or fever	
<b>Advil tablets</b> (ibuprofen)	po	200 mg. 400 mg.	Q6 hr. as needed for pain or fever	
<b>Benadryl capsules</b> (diphenhydramine hydrochloride)	po	25 mg. 50 mg.	Q4 hr. as needed for allergic reaction, hives	
<b>TUMS</b>	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:** \_\_\_\_\_