



Dear Parent/Guardians:

Our Lady of the Sacred Heart School supports New York State in their recognition of the importance of medical supervision and the need for annual preventive physical examinations. In addition, the school recognizes the strong connection in academic achievement and physical, emotional and medical wellness.

**PLEASE NOTE:**

**New York State Mandates Physical Examinations for:**

1. Students attending grades Kindergarten, 2, 4 & 7<sup>th</sup>
2. Students transferring into Our Lady of the Sacred Heart School
3. The physical exam must be done within the last 12 months of the student entering school.
4. Sports physicals must be done every 12 months.

Area physicians have designed a universal form to assist in streamlining the physical examination reporting system. ***This universal form/physical will be acceptable for both the mandated physical and sport physical.***

The school encourages you to continue good health practices by having your child receive annual preventive physicals and by collaborating with the school health office to meet the state mandates. If you should have any questions, please call the school health office.

Sincerely in Christ

Mr. Christopher Gardon  
Principal

# HEALTH SERVICES INFORMATION

**Physical Exams:** Physical examinations are required for students in grades kindergarten, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup> and any student new to Our Lady of the Sacred Heart School.

**Preventative Screening:** During the school year students are screened for possible difficulties in the following areas:

- A. Vision
- B. Hearing
- C. Height and weight
- D. Postural Defects (Scoliosis for grades 5 - 8)

**Notification of Defects to the Parents:** Parents are notified of health concerns found in all health appraisals. Notification should be returned as soon as possible stating the action taken. The Health Office Staff welcomes information relative to your child's health. We are willing to assist you in referral for health care and health education.

**Continuous Health Records:** Please assist us in keeping your child's health record up-to-date by notifying the health office of any new physical condition, treatments, or immunizations for your child.

**Notification:** Parents will be notified of serious injury or illness. Parents are responsible for the transportation of ill children to home. Emergency phone numbers and details will be obtained from the student's emergency information sheet. **PLEASE NOTIFY THE SCHOOL OF ANY CHANGES IN YOUR WORK OR HOME PHONE NUMBERS.** If the parents are unable to be reached, the emergency contact sheet should reflect who is allowed to pick your child up if we are unable to reach you. Please make sure that these adults as listed HAVE ACCESS TO A CAR AND ARE AVAILABLE DURING SCHOOL HOURS.

**Attendance:** Please encourage regular school attendance as each day adds a step in his/her total development. However, please keep your child home if he/she shows any suspicious symptoms such as sore throat, rash, colds, persistent cough, fever (anything over 100 degrees), "weepy lesions" about the nose or mouth, inflamed eyes or symptoms of a contagious disease. Please call the school if your child is absent.

**Medication Policy:** If it is necessary for your child to take medication during school hours, New York State Law requires a written NOTE FROM THE PARENT, and a written NOTE FROM THE DOCTOR. The supply of medications must be brought to the Health Office BY AN ADULT IN THE PHARMACY CONTAINER. This law applies to all medications including INHALERS, PAIN MEDICATION, COUGH DROPS, AND ALL OVER THE COUNTER MEDICATION.

**Physical Education Program:** Please inform the school if your child is unable to participate in a full physical education program (gym and swim). New York State Law requires a DOCTOR'S WRITTEN STATEMENT if a child is to be excluded from gym for a length of time (i.e. over 1 week). A doctor's permission is required for re-entry into the physical education program after a serious illness, sutures, surgery, fractures or other injuries.

**Care for Injuries:** School authorities may provide emergency care for illness and injuries which occur WHILE THE STUDENT IS IN SCHOOL. Treatment is limited to FIRST AID ONLY. HOME injuries are the responsibility of the parents/guardians.

If you have any questions regarding the health or health care of your student, feel free to call your School Nurse.

Thank you.

**West Seneca Central School District  
CONFIDENTIAL HEALTH HISTORY**

**TO BE COMPLETED BY PARENTS**

Registration Date \_\_\_\_\_

Pupil's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Last) (First) (Middle)

Birth Place \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_  
(Number) (Street) (Town) (Zip Code)

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Health Care Provider's Name \_\_\_\_\_ Health Care Provider's Phone Number \_\_\_\_\_

**Preschool History: Please give dates (if they apply) – use other side to explain further.**

Anemia	Nephritis	Joint Problems	Frequent Colds
Chicken Pox	Pneumonia	Bladder Problems	Operations
Diabetes	Rheumatic Fever	Allergies to Insect Stings	Fractures
Epilepsy	Scarlet Fever	Asthma	Serious Injuries
Heart Disease	Strep Throat	Other Allergies	Scoliosis
Hepatitis	Mononucleosis	Ear Conditions	Convulsions
		Fainting Spells	Staring Spells

SPECIAL TESTS	DATE	RESULT	TAKEN BY WHOM
Tuberculin Tests			
X-Rays			
Electrocardiogram (Heart EKG)			
Electroencephalogram (Brain Wave EEG)			
Allergy Tests			
Blood Tests			

Does child have allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what is the allergy and describe reaction. Explain on back. →

Does child have any congenital abnormalities or defects? If yes, please explain on back. →

Has child been hospitalized for any illnesses, injuries, or operations? \_\_\_\_\_ If yes, please give dates and explain on back. →

Any vision problems? \_\_\_\_\_ Has this child had an eye exam? \_\_\_\_\_ Eye surgery? \_\_\_\_\_ Eyes patched? \_\_\_\_\_

Eye exercises? \_\_\_\_\_ Wears glasses? \_\_\_\_\_ Explain on back. →

Have any history of hearing loss? \_\_\_\_\_ Repeated ear infections? \_\_\_\_\_ Tubes in ears? \_\_\_\_\_ Date(s) \_\_\_\_\_

Is his/her speech understandable to others? \_\_\_\_\_

Does this child take any medication routinely (excluding vitamins)? \_\_\_\_\_ If yes, what medicine, how often taken, and for what reason? \_\_\_\_\_

Will it be necessary to take medicine during school hours? \_\_\_\_\_

Are there any special problems or conditions we should know about to better understand your child? \_\_\_\_\_

**REGARDING THE GROWTH AND DEVELOPMENT OF THIS CHILD**

Birth weight \_\_\_\_\_ Premature birth? \_\_\_\_\_ Age at which your child Walked \_\_\_\_\_ Toilet trained \_\_\_\_\_

Age at which your child Used single words \_\_\_\_\_ Simple sentences \_\_\_\_\_

History of any identified medical concerns \_\_\_\_\_

If you wish to have a conference scheduled with the school nurse, please check here.

**The back of this form may be used for any additional information or explanations.**

# WEST SENECA CENTRAL SCHOOL DISTRICT RECORD OF STATE MANDATED IMMUNIZATIONS

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

New York State Public Health Law, Section 2164 mandates that schools shall not permit a child to be admitted unless the parent provides the school with a certificate of immunizations.

The required immunizations are:

- \* Three doses of **Diphtheria Toxoid** (usually administered as DPT, DT, DTaP, or TD)
- \* One dose of **Tdap** (Adacel or Boostrix) entering 6th grade **and** who are 11 years of age or older.
- \* Three doses of **Pertussis and Tetanus** for children born on or after January 1, 2005.
- \* Three doses of **Polio** vaccine.
- \* Three doses of **Hepatitis B** (K-12 students born on or after 1/1/93; preschool children born on or after 1/1/95.)
- \* Two doses of **Measles** vaccine, the first administered after 12 months of age and the second after 15 months of age. One dose for preschool children.
- \* One dose of **Mumps** vaccine administered after 12 months of age.
- \* One dose of **Rubella** vaccine administered after 12 months of age.
- \* Three doses of **Haemophilus Influenzae Type B** (HIB) conjugate vaccine or 1 HIB, if administered over 15 months of age. (Preschool children only)
- \* One dose of **Varicella** vaccine (all children born on or after 1/1/1998) enrolled in any schc  
Dose must be administered after 12 months of age.

## IMMUNIZATIONS : (Give full dates)

Diphtheria: \_\_\_\_\_

MMR: \_\_\_\_\_

Tdap , Adacel or Boostrix: \_\_\_\_\_

Polio: \_\_\_\_\_

Pertussis/Tetanus: \_\_\_\_\_

Hib: \_\_\_\_\_

Hepatitis B: \_\_\_\_\_

Varicella: \_\_\_\_\_

Other (Specify): \_\_\_\_\_

\_\_\_\_\_  
(Print or type healthcare provider's name)

\_\_\_\_\_  
(Healthcare provider's signature)

\_\_\_\_\_  
(Date)

## HEALTH APPRAISAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached  
 No immunizations given today  
 Immunizations given since last Health Appraisal:

Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
 PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Elevated Lead:  Yes  No  Not done Date: \_\_\_\_\_  
 Dental Referral  Yes  No  Not done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Specify current diseases:  Asthma Diabetes:  Type 1  Type 2  Hyperlipidemia  Hypertension  
 Other: \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Vision - without glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td style="text-align: center;">Referral</td> </tr> <tr> <td style="text-align: center;">Vision - with glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Vision - Near Point</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> </table>	Vision - without glasses/contact lenses	R	L	Referral	Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
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Vision - with glasses/contact lenses	R	L															
Vision - Near Point	R	L															
Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L															

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis:  Negative  Positive: \_\_\_\_\_  
 Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

### MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed  Yes  No Student may self carry and self administer medication  Yes  No  
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:  
 \_\_\_ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.  
 \_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: \_\_\_\_\_  None  
 Known or suspected disability: \_\_\_\_\_  Please monitor  
 Restrictions: \_\_\_\_\_  Please monitor  
 Protective equipment required:  Athletic Cup  Sport goggles/impact resistant eyewear  Other: \_\_\_\_\_

(Stamp below)

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# WEST SENECA CENTRAL SCHOOL DISTRICT

**James K. Brotz**  
Superintendent of Schools

**Mr. Charles J. Lehman**  
Assistant Superintendent  
Pupil Services

Dear Parent/Guardian:

## NEW YORK STATE GUIDELINES FOR ADMINISTRATION OF MEDICATION IN A SCHOOL SETTING

School nurses, principals, and other school personnel are often asked to dispense internal medication to school children. Internal medication can only be dispensed under the following policy:

1. **A written request from the parent/guardian.**
2. **A written request from the physician, which indicates the frequency and the dosage of the prescribed medication.**
3. **The medication is to be brought in the prescribed-labeled bottle by an adult to the office.**

**Please do not send aspirin, cold pills, cough drops, inhalers etc. to school with your child. The dangers of this practice are possible choking and consumption of medication by another student resulting in serious consequences.**

As stated above, medication will only be dispensed under the described conditions and this will be strictly adhered to within the school setting.

Please keep a copy of this notice for your records and forward the attached form to the school nurse.

Sincerely,  
Charles J. Lehman  
Assistant Superintendent

HS82b-10/00

Please Detach and Return to School

I, \_\_\_\_\_, have received a copy of the New York State  
(Please print parent/guardian name)

Guidelines for Administration of Medication in a School Setting.

Name of Student: \_\_\_\_\_  
(Please print name)

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Room: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_