New York State Education Law REQUIRES

- IMMUNIZATION RECORD be provided by parent or guardian to be admitted

- A current physical is not required for school entry but must be submitted within 30 days of the start except if the student will be playing a sport.*see below for sports eligibility.

- Tuberculin Screening Form properly completed by Health Care Provider is now recommended, but not required. The Health Care Provider may address this on the physical form.

All forms are enclosed in this packet.

ATHLETIC PARTICIPATION
Athletic registration is totally digital.
All parents of student athletes MUST create a profile in order to play sports on the FamilyID link below.
A physical exam performed within 12 months of the start of the sport is necessary and it MUST be documented on the ‘REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM’ included in this packet, or on the FamilyID Stepinac registration page. Per NYS law, if it expires during the sport season the athlete may continue to play through the season.
NO OTHER FORM IS ACCEPTED FOR SPORT PARTICIPATION.
Completed forms may be uploaded to FamilyID or sent to the school nurse. Final athletic clearance to participate is upon approval of the school nurse.

https://www.familyid.com/archbishop-stepinac-high-school
The following enclosed pages are:

IMMUNIZATIONS REQUIREMENTS

ANNUAL PHYSICAL FORM:
- Not necessary for school entry, but should be provided within 30 days of start.

TUBERCULIN SCREENING FORM (this may be addressed on physical form)

MEDICAL HISTORY FORM:
- Not necessary, but should be provided so that we can provide an optimal learning and health environment for your son.

*ADMINISTRATION OF MEDICATION FORM

Must be completed by Health Care Provider and Parent for all students who will require medications during school hours. This includes ALL OVER THE COUNTER medications.

This includes medicine which your son carries with him, such as inhaler or epi-pen and all over the counter medications.

Daily medications (pills) that must be administered by the nurse and kept in the Health Room.
REQUIRED IMMUNIZATIONS FOR SCHOOL ENTRY

HEALTH CARE PROVIDER FORMS ARE ACCEPTABLE AND PREFERRED

Student Name: ______________________________  DOB: ______________________________

DTaP/DT/TD (3+) ________________________________________________________________

TDAP (1) ______________________________________________________________________

OPV/IPV (3+)____________________________________________________________________

MMR (2) ______________________________________________________________________

VARICELLA (2) __________________________________________________________________

HEPATITIS B (3) __________________________________________________________________

MENINGITIS: (1)_________________________________________________________________

Must have at least (2) to enter 12th grade. (1) dose if the first was given at 16 years or older.

______________________________________________________________________________

The following immunizations are not required for school entry, but are recommended:

Hepatitis A (2) __________________________

Gardasil (HPV) (3) ___________ ___________ ___________

Other:

______________________________________________________________________________

Health Care Provider:  SIGNATURE ________________________________

Date: ____________________________ STAMP
**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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex: □ M □ F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

### HEALTH HISTORY

**Allergies** □ No □ Yes, indicate type □ Food □ Insects □ Latex □ Medication □ Environmental □ Anaphylaxis Care Plan Attached

**Asthma** □ No □ Yes, indicate type □ Intermittent □ Persistent □ Other: □ Asthma Care Plan Attached

**Seizures** □ No □ Yes, indicate type □ Type: □ Seizure Care Plan Attached

**Diabetes** □ No □ Yes, indicate type □ Type 1 □ Type 2 □ HgbA1c results: □ Diabetes Medical Mgmt. Plan Attached

**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

<table>
<thead>
<tr>
<th>Tests</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD/PRN</td>
<td>□</td>
<td>□</td>
<td>One Functioning: □ Eye □ Kidney □ Testicle</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>□</td>
<td>□</td>
<td>□ Concussion – Last Occurrence:</td>
<td></td>
</tr>
</tbody>
</table>

**Lead Level Required Grades Pre-K & K** Date

□ Test Done □ Lead Elevated > 10 µg/dL □ 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: **Diagnoses/Problems (list) ICD-10 Code**

□ Additional Information Attached
## SCREENINGS

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Color</td>
<td>□ Pass □ Fail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hearing

<table>
<thead>
<tr>
<th>Right dB</th>
<th>Left dB</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scoliosis Required for boys grade 9</td>
<td>Negative</td>
<td>Positive</td>
<td>Referral</td>
</tr>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td>□</td>
<td>□</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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
    - □ 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:
    - 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
  - □ Insulin Pump/Insulin Sensor*
  - □ Protective Equipment
  - □ Colostomy Appliance*
  - □ Medical/Prosthetic Device*
  - □ Sport Safety Goggles
  - □ Hearing Aids
  - □ Pacemaker/Defibrillator*
  - □ 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 NYSIS

Received Today: □ Yes □ No

### HEALTH CARE PROVIDER

Medical Provider Signature: 

Provider Name: (please print) 

Provider Address: 

Phone: 

Fax: 

Date: 

Stamp: 

Please Return This Form To Your Child’s School When Entirely Completed.
TUBERCULIN SCREENING FORM

Student Name: ___________________________ Date of Birth: ____________________

Dear Health Care Provider,

As you know, universal tuberculin testing is not recommended in the U.S. and other low-incidence countries due to the high rate of false positive results. There are some times, however, when tuberculin testing is indicated. If the answer to any of the following questions is “yes,” a child may be at risk for TB and a PPD (Mantoux) skin test should be administered.

1. Did the child emigrate from a country with a high incidence of TB (MOST COUNTRIES OF Asia, Africa, Central and South America, Russia, Haiti and Dominican Republic)?
2. Did the child travel to a high-incidence country for more than one month (where housing was with family members, not hotels)?
3. Did the child have household contact with parents or others who emigrated from a country with a high incidence of TB and tuberculin status unknown?
4. Was the child exposed to individuals in the past 5 years who were HIV-infected, homeless, residents of nursing homes, institutionalized, users of illicit drugs, incarcerated?
5. Does the child have HIV infection, diabetes mellitus, chronic renal failure, malnutrition, reticuloendothelial disease or other immunodeficiency’s or is the child receiving immunosuppressive therapy?

STEP 1: HCP must check and complete either “A” or “B” below:

A. Tuberculin testing is not indicated; OR
B. PPD (Mantoux) testing is indicated. The test was administered on _________ and was read on _________. The result in mm was: _________. (Must be within one year of school entrance. If the results were positive, indicate the date of the mandatory chest x-ray ______________.)

STEP 2: HCP must sign this form below and complete the rest of the information.

Physician/Practitioner’s Signature ____________________________________________

Name (please print) _________________________________________________________

Address: __________________________________________________________________

City/State/Zip: ___________________________ Phone # ________________________
STUDENT MEDICAL HISTORY FORM

STUDENT_______________________________________ DOB_____________________

PARENT CONTACT INFORMATION____________________________________________________

PAST AND PRESENT HEALTH ISSUES

_____ Anemia       _____ Headaches       _____ Asthma       _____ Heart Disease

_____ Cancer       _____ Hypertension     _____ Diabetes     _____ Immune Deficiency

_____ Hearing Loss _____ Seizures        _____ Skin Rash     _____ Fainting

_____ Vision Loss   _____ Allergies to food or medicine

_____ Emotional Disability or Mental Illness

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

Has your son ever had a serious injury / fracture or other issue that required hospitalization or surgery? If yes, please explain:

Does your son require glasses/contacts or hearing aids? Does your son take medication on a regular basis?

_____ I DO give the nurse permission to discuss my son’s health issues with his educational team on a “need to know basis”

_____ I DO NOT give the nurse permission to discuss my son’s health with his educational team
WHITE PLAINS CITY SCHOOL DISTRICT

Permission to Administer Multiple Medications

Student Name: ________________________ DOB: ________________________
Grade: ____________________ Teacher/HR: ____________________ School: ____________________

To Be Completed By Health Care Provider

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
<th>Initial applicable boxes below</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ AM _______ ☐ FT ☐ SSA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Self-Directed ☐ Self Admin-Self Carry</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ AM _______ ☐ FT ☐ SSA</td>
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<td>☐ Self-Directed ☐ Self Admin-Self Carry</td>
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<td></td>
<td>☐ AM _______ ☐ FT ☐ SSA</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Self-Directed ☐ Self Admin-Self Carry</td>
</tr>
</tbody>
</table>

Prescriber please use codes below for each medication ordered:

AM  Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication
FT  Medication is needed on field trips
SSA Medication is needed school sponsored extra-curricular activities
Self-Directed I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.
Self-Administer/Self-Carry I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name and Title of Licensed Prescriber (Please Print)

Prescriber’s Signature ________________________ Date ________________________ Phone ________________________

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child’s name on it.

Note: Students may only self-carry Epinephrine Auto Injectors or asthma inhalers.

Parent/Guardian Signature ________________________ Date ___________ Phone ___________

Self-Administer/Self Carry

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature ________________________ Date ___________ Phone ___________

School Nurse: ________________________ School ________________________
Phone: ________________________ Fax: ________________________ Email ________________________