ישיבת הדר אברהם צבי
Adolph H. Schreiber Hebrew Academy of Rockland

Dear Parent or Guardian:

Welcome to Adolph Schreiber Hebrew Academy of Rockland. The focus of this school's Health Office is wellness. We are concerned with immunizations, physical health examinations and the necessary health requirements needed to meet New York State guidelines. The aim of this letter is to orient you with the various aspects of the services that we offer.

First, I would like to convey the following information so that you will be able to make the necessary decisions regarding physical examinations and immunizations. All new entrants to the School District must have a physical examination. The physical can be within the past year. In addition, NYSDOH requires that all students in the following grades have physical examinations, **Kindergarten, 1st, 3rd, 5th and 7th.** If your child had a physical over the summer, please submit a copy to the Health Office as this will meet the mandate. Students can have a free school physical examination or you can submit a private physical. A private physical is recommended because your doctor knows your child and has the time for a more thorough examination.

As you know, New York State Department of Health has immunization requirements. Education Law requires that every child attending school submit proof of the immunizations mandated by NYSDOH**. Parents must provide evidence of a child's vaccination before he/she can be admitted to school.** Please submit a copy of your child's medical immunization record along with your application for admission.

There are times when a child may need medical treatment while attending school. The school nurse can administer medication and or medical treatment **if it is ordered by a physician.** There is a Medication Request Form that can be completed by your physician and by the parent. Please call me at 845-357-1515, extension 508 so that I can assist you. Please note that these discussions are confidential.

If you have any questions, please feel free to call me at the above.

Sincerely,

Carren Teitelbaum, RN, BSN, NCSN
ASHAR- School Nurse

# *EAST RAMAPO CENTRAL SCHOOL DISTRICT*

OFFICE OF SPECIAL STUDENT SERVICES
Mail to ASHAR: 360 New Hempstead Rd, New City, NY 10956
ASHAR Phone: (845) 357-1515 ♦ ASHAR Fax: (845) 357-1516 ♦ EMAIL: nurse@ashar.org

Dear Parent/Guardian:

The New York State Department of Education requires that all new students and students in grades Kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th have a physical examination completed by a health care provider. A physical examination form is enclosed in this packet. If you prefer to have your child examined by a private physician it is imperative that the completed physical examination form be returned to the school nurse by October 1.

If the school nurse does not receive the completed physical examination form, an appointment will be scheduled for your child with a school district physician. The school health physical includes an assessment of the ears, mouth, heart, lungs, spine, and genitalia. Students will also be assessed according to the Tanner stages of puberty.

Please call the school nurse indicated below with any questions or concerns.

Thank you for your attention to this matter.

Sincerely,

Christine Healy, RN, MSN
Coordinator of Health Services

| | |
|---|---|
| Carren Teitelbaum, RN, BSN, NCSN | (845)357-1515 x508 |
| School Nurse | Phone Number |

# *EAST RAMAPO CENTRAL SCHOOL DISTRICT*

OFFICE OF SPECIAL STUDENT SERVICES
105 South Madison Avenue, Spring Valley, NY 10977
Phone: (845) 577-6040
Fax: (845) 577-6059

**New Entrants Health History**
**Health/Safety Clearance to Participate in Physical Education**
Based on Sections 903 and 3204 of the Education Laws

*Pending the receipt of a completed medical history and physical examination form from your health care provider, we are asking that you provide the following information.*

Students Last Name/First Name _____ Date of Birth _____ Grade/Class _____

1. Does your child have a history of the following? If yes, please explain:

| | | | |
|---|---|---|---|
| ALLERGIES | Yes_____ | No_____ | _____ |
| SEIZURES | Yes_____ | No_____ | _____ |
| VISION PROBLEM | Yes_____ | No_____ | _____ |
| HEARING PROBLEM | Yes_____ | No_____ | _____ |
| MOTOR DEFICIT | Yes_____ | No_____ | _____ |

2. Has your child had any of the following? If yes, please explain:

| | | | |
|---|---|---|---|
| SERIOUS ILLNESS | Yes_____ | No_____ | _____ |
| SERIOUS INJURY | Yes_____ | No_____ | _____ |
| SURGERY | Yes_____ | No_____ | _____ |
| BONE FRACTURE | Yes_____ | No_____ | _____ |

3. Please check if your child has a history of any of the following:

| | | |
|---|---|---|
| _ASTHMA | _CHICKENPOX | _RHEUMATIC FEVER |
| _DIABETES | _WHOOPING COUGH | _TUBERCULOSIS |
| _HEART ANOMALY | _OVERWEIGHT | _POSITIVE PPD |
| _HYPERTENSION | _HEPATITIS A | _SCOLIOSIS |
| _FREQUENT EAR INFECTIONS | | -HYPERLIPIDEMIA |

Please explain:_____
_____

4. Is your child presently or was your child under medical treatment during the past year? Yes___ No___ If yes please explain_____
_____

5. Last Physical Exam Date:_____Physician's Name_____

6. Is your child taking medication on a regular basis? List the medication, dosage and frequency.
_____
_____

7. Is there any other medical information we should know about your child?_____
_____

_____
PRINT Name of Person Completing Form Relationship to Child Signature Date

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**
**TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**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<br>☐ Yes, indicate type | Type:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| **Asthma** ☐ No<br>☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other :<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| **Seizures** ☐ No<br>☐ Yes, indicate type | Type:<br>☐ Medication/Treatment Order Attached<br>Date of last seizure:<br>☐ Seizure Care Plan Attached |
| **Diabetes** ☐ No<br>☐ Yes, indicate type | Type: ☐ 1 ☐ 2<br>☐ Medication/Treatment Order Attached ☐ 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 ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

**Height:** **Weight:** **BP:** **Pulse:** **Respirations:**

| Laboratory Testing | Positive | Negative | Date | List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ) |
|---|---|---|---|---|
| TB- PRN | ☐ | ☐ | | |
| Sickle Cell Screen-PRN | ☐ | ☐ | | |
| **Lead Level Required Grades Pre- K & K** | | | **Date** | |
| ☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL | | | | |

☐ **System Review and Abnormal Findings Listed Below**

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine | ☐ Skin | ☐ Social Emotional |
| ☐ Neck | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ Musculoskeletal |

| | |
|---|---|
| ☐ Assessment/Abnormalities Noted/Recommendations:<br><br>☐ Additional Information Attached | Diagnoses/Problems (list) ICD-10 Code*<br><br>*Required only for students with an IEP receiving Medicaid |

| Name: | DOB: |
|---|---|

**SCREENINGS**

| **Vision** (w/correction if prescribed) | **Right** | **Left** | **Referral** | **Not Done** |
|---|---|---|---|---|
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | ☐ |
| Near Vision Acuity | 20/ | 20/ | | ☐ |
| Color Perception Screening ☐ Pass ☐ Fail | | | | ☐ |
| Notes | | | | |

| **Hearing** Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz. | | | **Not Done** |
|---|---|---|---|
| Pure Tone Screening | **Right** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes ☐ No | ☐ |
| Notes | | | | |

| **Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7 | **Negative** | **Positive** | **Referral** | **Not Done** |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ Yes ☐ No | ☐ |

**RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK**

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

**Developmental Stage for Athletic Placement Process <u>ONLY</u> required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

**MEDICATIONS**

☐ **Order Form for Medication(s) Needed at School Attached**

**IMMUNIZATIONS**

☐ Record Attached ☐ Reported in NYSIIS

**HEALTH CARE PROVIDER**

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

**Please Return This Form To Your Child's School When Completed.**

# 2022-23 School Year
# New York State Immunization Requirements for School Entrance/Attendance[1]

**NOTES:**
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

| Vaccines | Prekindergarten (Day Care, Head Start, Nursery or Pre-k) | Kindergarten and Grades 1, 2, 3, 4 and 5 | Grades 6, 7, 8, 9, 10 and 11 | Grade 12 |
|---|---|---|---|---|
| **Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]** | **4 doses** | **5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older | **3 doses** | |
| **Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]** | **Not applicable** | | **1 dose** | |
| **Polio vaccine (IPV/OPV)[4]** | **3 doses** | **4 doses or 3 doses** if the 3rd dose was received at 4 years or older | | |
| **Measles, Mumps and Rubella vaccine (MMR)[5]** | **1 dose** | **2 doses** | | |
| **Hepatitis B vaccine[6]** | **3 doses** | **3 doses** **or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years | | |
| **Varicella (Chickenpox) vaccine[7]** | **1 dose** | **2 doses** | | |
| **Meningococcal conjugate vaccine (MenACWY)[8]** | **Not applicable** | | **Grades 7, 8, 9, 10 and 11: 1 dose** | **2 doses or 1 dose** if the dose was received at 16 years or older |
| **Haemophilus influenzae type b conjugate vaccine (Hib)[9]** | **1 to 4 doses** | **Not applicable** | | |
| **Pneumococcal Conjugate vaccine (PCV)[10]** | **1 to 4 doses** | **Not applicable** | | |

NEW YORK STATE | Department of Health

**SAMPLE**

# Dental Health Certificate- Optional

**Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.**

## Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

## Section 2. To be completed by the Dentist/ Dental Hygienist

**I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:**

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist's/ Dental Hygienist's name and address**

**(please print or stamp)**

**Dentist's/Dental Hygienist's Signature**

***Optional Sections - If you agree to release this information to your child's school, please initial here.***

### II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

### II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

(3/2018)

## *EAST RAMAPO CENTRAL SCHOOL DISTRICT*

OFFICE OF SPECIAL STUDENT SERVICES
Mail to ASHAR: 360 New Hempstead Rd, New City, NY 10956
ASHAR Phone: (845) 357-1515 ♦ ASHAR Fax: (845) 357-1516 ♦ EMAIL: nurse@ashar.org

# MEDICATION REQUEST

School personnel are aware that under certain circumstances it may be absolutely necessary for a student to take medication during school hours. The school nurse may administer medication that is ordered by a physician. The parent must also request in writing that such medication be administered to the student.

**ALL MEDICATION MUST BE PROPERLY LABELED BY THE PHARMACIST AND MUST INCLUDE THE STUDENT'S NAME, NAME OF DRUG, DOSAGE, TIME OF ADMINISTRATION AND DATE.**

**IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO DELIVER ALL MEDICATION TO THE SCHOOL NURSE. STUDENTS ARE NOT PERMITTED TO BRING THEIR OWN MEDICATION TO SCHOOL.**

Medication should be given during school hours only if a schedule cannot be worked out whereby the medication can be given at home. All requests must be accompanied by the physician's and parent's signature.

---

**Student's Name**:_____ **Date**_____

Classroom/Homeroom Teacher_____ Grade_____

**Diagnosis**:_____ **Medication:**_____ **Dosage**:_____

**Route**:_____ **Time**_____ **Side Effects**_____

Duration of time medication is to be given_____

_____

**Physician Signature and Stamp** **Phone No.** **Date**

_____

**License #** **NPI #**

_____

**Parent/Guardian Signature** **Phone No.** **Date**

Rev11/2022