BEDFORD CENTRAL SCHOOL DISTRICT
THE FOX LANE CAMPUS · P.O. BOX 180
MOUNT KISCO, NEW YORK 10549

Dr. Robert Glass
Superintendent of Schools

Dr. Louis Corsaro
Medical Director

Student Health Requirements for Entrance to School

Dear Parent/Guardian:

The School Health Service Staff welcomes you and your child to the Bedford Central Schools. Our primary interest is the well-being of your child. Please review the attached forms and have them completed as specified. Return all forms to your school nurse.

CERTIFICATE OF IMMUNIZATION: REQUIRED PRIOR TO SCHOOL ATTENDANCE

The following are acceptable forms:

1. The enclosed BCSD Certificate of Immunization or any form listing all the required immunizations that is signed by your physician or licensed healthcare provider.
2. A military childhood immunization record or other medical health record.

Please see the attached for what is accepted as the *minimum immunization requirements* for school attendance according to NYS Education Law and Public Health Law.

If a student has incomplete immunizations, the parent/guardian must show acceptable proof that the child is "in process of receiving" the required immunizations.

1. A child must have received at least one dose of each vaccine and;
2. The parent/guardian must provide the date(s) of appointments with a specified healthcare provider or facility for completion of the required immunization(s).

The school will then allow the child to enter and/or attend school but will maintain supervision until the process has been completed or exclude the child if the parent/guardian defaults. The Principal or other person in charge of any school is required by law to refuse to admit a child to school without acceptable proof of required immunizations or exemption.

PHYSICAL EXAM: REQUIRED PRIOR TO SCHOOL ATTENDANCE

All new entrants (including out of district/state transfers) are required to have a physical exam dated *within one year of the first day of school.* Please have your child's healthcare provider complete the attached **mandated** form, sign and return the physical exam to your child's School Nurse. ALL information must be completed on the physical exam form.

HEALTH HISTORY: REQUIRED PRIOR TO SCHOOL ATTENDANCE

In order to keep a current and accurate health file on your child, please complete and return the health history form with the school physical form to your child's School Nurse.

DENTAL EXAM: RECOMMENDED PRIOR TO SCHOOL ATTENDANCE

Please have the dental form completed and signed by your child's dentist and returned with your child's physical form.

Thank you for your cooperation in this health endeavor. Our students benefit when we work together to promote the health and achievement of all students. Please call the school Health Office with any questions or concerns.

Yours truly,

School Health Services

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Dear Parent/Guardian,

We are working diligently to create a safe and healthy environment and look forward to welcoming all our students back to school in September.

It is the aim of the Bedford Central School District for each child to have a health examination every year. However, New York State Education Law requires children to have a physical examination if they are entering: **Pre- K, Kindergarten, grades 1, 3, 5, 7, 9 and 11.**

Schools cannot accept the health exam if it is not on the required NYS Health Examination Form.

It is now more important than ever to keep up with your child's well visits and remain up to date with your immunizations.

The exam is valid if it is within the twelve months prior to the start of the school year. Any physical performed by a New York State physician on or after September 1, 2022 will be considered current.

The required physical and dental examination forms are posted on the school's website for you to print.

Thank you for your cooperation and please feel free to contact me with any questions or concerns.

Sincerely,

BCSD School Nurses

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 ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ 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
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **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:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11

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 ONLY 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, prosthetic, 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.

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New York State Required Immunizations

STUDENT'S NAME: _____ **DOB:** _____ **Grade:** _____

DPT/DTaP/DT: *5 full dates required: (unless 4th dose was received at 4years of age or older or 3 doses if 7 years or older and the series was started at 1 year or older)*

#1_____ #2_____ #3_____ #4_____ #5_____

Tdap: *1 full date required on or after 11th birthday:* _____

POLIOMYELITIS: **4 doses required** (*unless 3rd dose was received at 4years of age or older)*
#1_____ #2_____ #3_____ #4_____

MMR Vaccine: *2 full dates required*: #1_____ #2_____

Mcgl Vaccine: *2 full dates required: (7th* **gr. & 12th gr.)** *or 1 dose if the dose was received at 16 years or older)* #1_____ #2_____

VARICELLA Vaccine: *2 full dates required*: #1_____ #2_____

HEPATITIS A Vaccine dates: *(not required but suggested)*
#1_____ #2 _____

HEPATITIS B Vaccine: *3 full dates required*: *(or 2 doses of Adult Hep B for children who received the doses at least 4 months apart between the ages of 11 through 15)*

#1_____ #2_____ #3_____

HIB Vaccine: *1 to 4 doses (required for preschool only): #1* _____
#2 _____ #3 _____ #4 _____

Pneumococcal Conjugate Vaccine (PCV): *1 to 4 doses (required for preschool only)*:
#1_____ #2_____ #3_____ #4_____

Disease History: **Chicken Pox (date):** _____ **Lyme (date):** _____

Signature of Physician: _____ **Date:** _____

Physician's Stamp: _____ **Tel No:** _____

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.

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Health History

Name of Student_____
□ Male □ Female **Grade**_____ **Date of Birth**_____

The School Health Services will gladly cooperate with you if your child has any health issues that might affect his/her education. Please update the following questions in order to help us in planning for a positive educational experience for your child.

1. History of serious illness or operations:_____

2. History of asthma/allergies:_____

3. Is your child currently receiving any medical treatment?_____

   _____

4. Is your child currently on any medications? □ Yes □ No

   If yes, please list medication(s)_____

5. Does your child wear glasses? □ Yes □ No
   Does your child wear contact lenses? □ Yes □ No

   If yes, under what conditions does he/she wear them?_____

6. Does your child have a hearing difficulty? □ Yes □ No

   If yes, please describe_____

7. Should your child be restricted from physical activity? □ Yes □ No

   If yes, please describe_____

8. Are there any special health needs you wish to bring to our attention such as problems of behavior, growth, or nutrition?_____

   _____

Please check the appropriate box:

- □ I give permission to the nurse to share this information with teachers and staff associated with my child's educational experience.
- □ I do not give permission to the nurse to share this information with teachers and staff associated with my child's educational experience.

_____ _____

Signature of Parent/Guardian

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Food Allergy History

Student Name: _____ Grade/Teacher: _____

Date of Birth: _____ Weight: _____

Parent/Guardian: _____ Contact Phone Number: _____
Primary Healthcare Provider/Allergist: _____

1. What is your child allergic to?

2. Is the allergy **tactile, ingestion or airborne?** (Circle all that apply).

3. Please circle the symptoms that your child has experienced in the past:

- **Skin:** localized hives, systemic (all body) hives, itching, rash, flushing, swelling of eyes/face/hands/arms/legs
- **Mouth**: itching, obstructive swelling of lips/tongue/mouth
- **Abdominal:** nausea, cramps, vomiting, diarrhea
- **Throat:** itching, tightness, hoarseness, cough, trouble swallowing
- **Lungs:** shortness of breath, repetitive cough, wheezing
- **Heart:** chest pain or tightness, weak pulse, dizzy, confusion, paleness, loss of consciousness, cyanosis (blueness)
- **Generalized feeling of doom/or that something bad is going to happen.**

4. What age was your child when the allergy was discovered? How was it discovered?

5. How many times has your child had *a mild reaction requiring the use of an anti-histamine*? (ie: Benadryl) What symptoms did your child have at this time?

6. Has your child ever had an ***anaphylactic (severe reaction)?*** Did it require the use of an epinephrine pen? If so, how many times?

7. Has your child ever been hospitalized or sent to the emergency room related to their food allergy? If yes, please explain.

8. What are the *early* symptoms of your child having an allergic reaction?

9. How does your child communicate his/her symptoms?

10. Is your child allowed to touch, play or eat with foods used in classroom activities that may have been processed in the same facility as the allergen that your child has? Is your child able to eat foods that have a food allergy warning on the package?

11. Does your child need to sit at a nut free table at lunchtime?

    Yes_____ No_____

12. Is your child asthmatic? If so, have they ever been hospitalized due to an asthmatic episode? Has a rescue inhaler been prescribed and do they use an aero chamber?

Checklist

- The Food Allergy Action Plan has been provided and reviewed with the School Nurse who will review it with the primary teacher(s).
- Two epinephrine pens along with a physician's prescription have been provided to the School Nurse. o If my child is asthmatic, a rescue inhaler has been provided with an aero-chamber to the School Nurse.
- It is my responsibility to pick up my child's epinephrine pens at the end of the school year from the School Nurse.

Parent Name:_____ Date: _____

Signature of Parent:_____

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Authorization for Use or Disclosure of Protected Health Information (HIPAA)

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, (parent name)_____authorize my child's healthcare provider(s) listed below:
Name:_____Phone:_____Fax:_____to release the medical records of my child,_____, DOB_____to the district's:

❒ Medical Director ❒ School Nurse ❒ Athletic Trainer (AT) ❒ Counselor Occupational Therapist (OT)
❒ Physical Therapist (PT) ❒ Psychologist ❒ Social Worker ❒ Speech Therapist (ST)
❒ Other: _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply):
❒ Immunizations ❒ Health Appraisals ❒ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ❒ Other: _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: check all that apply):

❑ To develop care or therapy plans for routine and emergent school management
❑ To design appropriate educational, school, or athletic programs
❑ To assess the impact of the medical condition(s) on school programming and/or attendance
❑ To share school observations/concerns surrounding behavior
❑ To assess a medical basis for modification of transportation and/or home tutoring
❑ Medication delivery or therapy prescriptions At patient's request with no specific purpose
❑ Other: _____

PARENT: Please select one:

❑ This authorization is valid for the entire academic school year 20 - 20_
❑ This authorization is valid for the duration of attendance within the school district
❑ This authorization shall expire on_____/____/_____(MM/DD/YYYY)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____	_____	_____
Parent/Guardian or Student if over 18	*Relationship*	*Date*

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD