CHAUTAUQUA LAKE CENTRAL SCHOOL
100 NORTH ERIE STREET
MAYVILLE, NEW YORK 14757

KEEP THIS PAGE FOR YOUR RECORDS

Dear parents:
You will find here a packet of forms and information from the **School Health Office.**

Medications
New York State law requires all medications given or used during the school day including over-the-counter medications be given only with student specific physician orders. (A *medication order form* is included in this packet to give to your health care provider if needed). Items that are considered over-the-counter medications include cough drops. If you have any questions about a particular product please call the school nurses at 753-5819.

Immunization Records
It is the responsibility of the parent/guardian to provide the health office with a record of your child's current immunizations. (A list of *required immunizations* is included in this packet). **This record is required prior to the student starting school**.

Physicals
School physicals are required on all newly enrolled students. (We have enclosed a copy of the school *physical form* to be given to your health care provider.) Your doctor must use this form. If your child has had a physical in the past 12 months please send in a copy or have your doctor fax us a copy. Our fax number is available below. **The physical must be submitted within thirty days of enrollment.**

Dental Certificates
New York State law now requires that school districts request a dental certificate on all newly enrolled students. (A sample *dental certificate* that your dentist may use is included with this packet). A list of dentists that provide free or reduced cost dental care is available from the school upon request.

Screenings
The health office routinely performs the following screenings: height, weight, (including BMI), vision, and color blindness, hearing, scoliosis and head lice as outlined by the *NYS Department of Education* and district protocol. Negative findings will be reported to the parent/guardian.

Health Office Information
Staff is available in the health office daily during school days from 7:30 AM to 3:15 PM
Phone Number 716-753-5819
Fax number 716-753-2085
Nurses: Michelle Holley RN mholley@clake.org
Terry Smith RN tsmith@clake.org

Please feel free to contact us any time should you have questions or concerns about your child. We strive to make your child's time here at Chautauqua Lake Central School a positive and enjoyable experience.

Chautauqua Lake Central School

Charting a course for the future

Keep this page for reference

When To Keep a Child Home With Illness

Sometimes it can be difficult for a parent to decide whether to send a child to school when he wakes up with early symptoms of an illness. In general, unless your child is significantly ill, the best place for him is in school.

To help maintain a healthy school environment remind and show your child to discard used tissues promptly, not to share personal items, to cover his mouth when he coughs or sneezes, to keep his hands away from his face, and to wash hands thoroughly and often with soap and warm water. To ensure sufficient washing time, suggest that he silently sing the Happy Birthday song twice while washing his hands.

There are some situations however, in which it is best to plan on keeping your child home for a day to rest or to arrange for an appointment with your health care provider. The following are a few such situations that warrant watching and possibly conferring with your health care provider:

- Persistent fever greater than 100.4° orally, including a fever that requires control with medication, like Tylenol
- Child is too sleepy or ill from an illness, like vomiting and/or diarrhea, to profit from sitting in class all day
- Significant cough that makes a child feel uncomfortable or disrupts the class
- Sore throat that is severe, accompanied by fever and/or feeling ill, that persists longer than 48 hours, OR after known exposure to a confirmed case of Streptococcal throat infection
- Honey-crusted sores around the nose or mouth that might be impetigo; or a rash in various stages including boils, sores and bumps that may be chicken pox; or a significant rash accompanied by other symptoms of illness such as fever
- Red, watery eyes or eyes with sticky matter, as these could be symptoms of a contagious eye condition such as pink eye
- Large amount of discolored nasal discharge, especially if accompanied by facial pain or headache
- Severe ear pain or drainage from the ear
- Severe headache, especially if accompanied by fever
- Any condition that you think may be serious or contagious to others

Children that are home from school due to a fever or have been sent home from school with a fever over 100.0 should to stay out of school until the fever is under 100.0 without the assistance of medication for at least 24 hours.

If you find a pattern of your child's asking to stay home from school, especially if she is falling behind or appears anxious by the thought of attending school, or if there does not appear to be any obvious physical symptom, it may be a good idea to contact your school nurse and your health care provider to discuss your concerns.

Remember, whenever you keep your child home from school, please call the Attendance Office in advance of the start of the school day and leave a message that your child will be absent.

If you have any questions or concerns, please do not hesitate to call the health office at 716-753-5819 and speak to one of the nurses.

Adapted from information provided by New York Statewide School Health Services Center, © Dr. Cindy Devore, MD

CHAUTAUQUA LAKE CENTRAL SCHOOL

Return this form to Health Office

STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breat ing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer reflux, IBS)
☐ Headaches/migrain s
☐ Heart Conditions
☐ High Blood Pressur
☐ Mental Health Conc ition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Sc liosis
☐ Si gle Organ (☐kidney, ☐testicle)
☐ Sk n Condition
☐ Sp eech Condition
☐ U inary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer ☐dietary restrictions

Please list any additional concerns: (use back of sheet if necessary)_____

_____

Parent/Guardian Signature:_____Date:_____

CHAUTAUQUA LAKE CENTRAL SCHOOL

Return this form to the Health Office

STUDENT EMERGENCY HEALTH RECORD

Please fill out **both sides** of this form and return to the school in the attached confidential envelope. To serve your child in case of a sudden illness, accident or school emergency evacuation, it is necessary that you furnish the following information.

Student's Name_____
Last First Middle

Address_____Zip_____

Mailing Address_____Zip_____

Home Phone #: _____Teacher_____Grade_____

Mother: _____ Cell Phone #:_____Work Phone #:_____

Father: _____Cell Phone #:_____Work Phone #:_____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

LIST TWO NEARBY RELATIVES OR NEIGHBORS WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED (Be sure to inform person listed.)

Name_____Name_____

Address_____Address_____

Phone_____Phone_____

Relationship to child _____Relationship to child_____

Child's Doctor _____Health Insurance Provider_____

List all allergies: _____

List all medications taken at home and/or at school**:** _____

_____

Other medical information (be specific): _____

_____

In the event physicians, other persons named on this document, or parents cannot be contacted, the school officials are authorized to take whatever actions are deemed necessary in their judgments, for the health of the aforesaid child.

I agree to provide and give permission for the use of FDA approved sunscreen on my child for avoiding overexposure to the sun. Check box if you **DO NOT** want sunscreen used. ☐

_____ _____

Signature of Parent Date

CHAUTAUQUA LAKE CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your healthcare provider will require the *Release of Information Form* below to share Protected Medical Information with the school district. Please sign and return this form to the school nurse promptly to avoid delays.

_____ _____
Student's Name Date of Birth

I,_____authorize my child's healthcare provider(s) listed below to release my
Parent's/Guardian's Name
child's medical records to **Chautauqua Lake Central School District's** medical director, physical therapist (PT), occupational therapist (OT), speech therapist (ST), school psychologist, school social worker, and/or school nurse.

HealthCare Providers:

Name:_____Phone:_____Fax: _____

Name:_____Phone:_____Fax: _____

Name:_____Phone:_____Fax: _____

The healthcare provider may disclose the following protected health information (check all that apply)

____ Health History

____ Physical Examination Report

____ Immunization Records

____ Past/current medical conditions and its impact on attendance, school programming and/or PT,OT, ST, Psych testing needs.

____ Other (specify)_____

_____.

Information received on your child will be used for one or more of the following:

1. To facilitate evaluation of your child's individual educational program.
2. To determine health needs of your child which may require special services during school.
3. To facilitate health counseling or school health services which you may wish for your child.
4. To provide school district personnel with a better understanding of your child's health needs.
5. At patient's request with no specific purpose.
6. Other: _____

This authorization may be revoked by you at any time in writing and automatically expires on June 30th at the end of the school fiscal year.

I understand that my child's treatment is not dependent on my agreement to release or withhold information

_____ _____ _____
Date Signature of Parent/Guardian Relationship to child

ALCOHOL BASED HAND SANITIZER

Careful hand washing with soap and water is the recommended method to keep hands clean and free of bacteria. If soap and water are not available and hands are not visibly soiled, alcohol based hand sanitizers (ABHS) are a convenient, effective and fast way to reduce the spread of germs.

To use an Alcohol Based Hand Sanitizer:

1. Apply a dime-sized amount of the product to the palm of your hand.
2. Rub hands together, covering all surfaces of your hands until your hands are dry.

"Things to Know":

1. Alcohol based hand sanitizers (ABHS) significantly reduce the number of germs on skin.
2. To be effective, alcohol based hand sanitizers are ethyl alcohol based.
3. Alcohol can be absorbed when ingested or applied to the skin.
4. Children should be supervised when using hand sanitizers.
5. Discourage fingernail biting and touching of the eyes, nose and mouth.

Alcohol Based Hand Sanitizer (ABHS) is available throughout the school building. The dispensers will be filled and maintained by the maintenance staff. Students are encouraged to use soap and water for hand cleaning. If this is not practical, ABHS will be available for student use under the supervision of staff.

Alcohol Based Hand Sanitizer (ABHS) is considered an "over-the-counter" medication in NYS. We have obtained standing orders from the School Medical Director to use this product. Only if you do **NOT** wish to have your child use this product please complete and return the attached form to the school health office.

Parental Consent Form

I do **not** want my child,_____to use
(Name) (Grade)

Alcohol Based Hand Sanitizer (ABHS) while at school.

Parent or Guardian Signature:_____.

Date:_____

RETURN THIS COMPLETED FORM TO THE HEALTH OFFICE

Chautauqua Lake Central School

Return to Health Office

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name:_____DOB: _____

Grade:_____Teacher/HR:_____ School: _____

I request the school nurse give the medication listed on this plan. I understand that the school nurse, or other trained, designated person will administer the medication. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Email **Phone Where We Can Reach You** ☐ **Check if Cell**

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis_____

Medication_____

Dose_____ Route_____ Time(s) _____

Recommendations_____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

_____

Email

Stamp

Return to:

School Nurse: M. Holley, RN / T. Smith, RN School: Chautauqua Lake Central School
School Address: 100 North Erie Street Mayville, New York 14757
Phone: (716) 753-5819 Fax: (716) 753-2085

Return this form to the Health Office

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 the 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 visit to a dentist? [ ] 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

I. **The Dental Health condition of** _____ **on** _____ **(date of exam)**

The date of the exam 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 name and address/please print or stamp)

Dentist'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): _____

III. 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.

IMPORTANT NOTICE TO PARENTS/PERSONS IN PARENTAL RELATION OF STUDENTS WITH LIFE-THREATENING HEALTH CONDITIONS

Definition of life-threatening health condition: A condition, including a known allergy, that will put the child in danger of death during the school day if a medication or treatment order is not in place (for example food or substance allergy, insect sting allergy, asthma, diabetes, seizure disorder, etc.).

If your child has a life-threatening health condition please immediately contact the School Health Office/School Office for a "Life-threatening Health Condition Packet" which includes the following:

[ ] Student Emergency Care Plan for the student's specific health condition;

[ ] Authorization for Administration of Medication in School;

[ ] Self-Medication Release Form.

The appropriate forms and any additional information you or the licensed health provider would like to share must be completed and returned to the School for review and approval by the School Nurse as soon as possible.

Reminder:

It is the parent/person in parental relation's responsibility to alert other school programs that their child has a health condition and/or a care plan in place.

Please report immediately any changes needed in emergency contact information, medication, health status, etc. to the School Office.

If you have any questions or concerns, please contact the Principal or the School Nurse assigned to your child's school.

Thank you for your assistance in helping us to provide a safe school experience for your child.

This form should be given to all parents/persons in parental relation at the time of registration or when school staff is notified that a student has a life-threatening health condition.

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 ☐ 99thand>

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:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*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.