VERNON VERONA SHERRILL CENTRAL SCHOOL

City School District of the City of Sherrill
5275 State Route 31, PO Box 128, Verona, New York 13478-0128 • Tel. (315) 829-2520 • Fax (315) 829-4949

CONSENT TO RELEASE RECORDS

To:_____ Date:_____

_____

_____

Please release my child's_____

records to the agency/school listed below.

_____
Parent/Guardian Signature

_____

_____
Address

_____
Date

Send records to:_____

_____

_____

Recommended / Sample Form

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / 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 _____

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):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ 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: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension
❑ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 2/08*

Medical Exemption for Required Immunization Request Form

NYSDOH Public Health Law Section 2164(7)(a) requires adequate dose or doses of immunizing agents against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, Haemophilus influenza type b (Hib), pertussis, tetanus, and hepatitis B for school entry.

New York State Law Section 66-1.3 (7) (c)-Requirement for School Admission permits medical exemption to required immunizations if the parent provides a certificate from a physician, licensed to practice medicine in New York State, that one or more of the required immunizations may be detrimental to the child's health.

The Centers for Disease Control's (CDC) resources on contraindications to vaccination can be found at: http://www.immunize.org/catg.d/p3072a.pdf .

Your certificate should include:

- The specific immunization that is medically contraindicated
- The reason for the medical contraindication
- The duration of the request

Please note that a physician should not request a permanent exemption unless you anticipate the child to have a life-long anaphylactic reaction to a given vaccine or one of its components, which cannot be desensitized, or the child has some other severe chronic medical condition you do not expect to resolve. All other requests should be temporary and require at minimum your annual re-assessment, if not sooner when the condition resolves.

To Be Completed By Health Care Provider

Student Name: _____ DOB: _____ Grade: _____

Teacher/HR: _____ School: _____

Name of Immunization which cannot be administered _____

Reason for exemption: _____

Duration of exemption: □ Academic year □ Other _____

❑ This immunization will never be given because of the following medical contraindications:

_____

❑ Unless otherwise advised, this immunization will be given on _____

Name of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____ Date _____ Phone _____

Please return this form to:

School Nurse: _____ School _____

Phone: _____ Fax: _____ Email _____

This document should be filed with the student's cumulative health record.

SAMPLE REQUEST FOR RELIGIOUS EXEMPTION TO IMMUNIZATION FORM
PARENT/GUARDIAN STATEMENT

Name of Student_____

Identification Number_____

Name of Parent(s)/Guardian(s)_____

School District and Building Name_____

This form is for your use in applying for a religious exemption to Public Health Law immunization requirements for your child. Its purpose is to establish the religious basis for your request since the State permits exemptions on the basis of a sincere religious belief. Philosophical, political, scientific, or sociological objections to immunization do not justify an exemption under Department of Health regulation 10 NYCRR, Section 66-1.3 (d), which requires the submission of:

> A written and signed statement from the parent, parents, or guardian of such child, stating that the parent, parents or guardian objects to their child's immunization due to sincere and genuine religious beliefs which prohibit the immunization of their child in which case the principal or person in charge may require supporting documents.

In the area provided below, please write your statement. The statement **must** address **all** of the following elements:

- Explain in your own words why you are requesting this religious exemption.
- Describe the religious principles that guide your objection to immunization.
- Indicate whether you are opposed to all immunizations, and if not, the religious basis that prohibits particular immunizations.

You may attach to this form additional written pages or other supporting materials if you so choose. Examples of such materials are listed on page 3.

Please continue your statement on page 2

Please sign in the space provided below and have the document notarized by a notary public where indicated.

I hereby affirm the truthfulness of the forgoing statement and have received **and** reviewed the informational immunization materials provided to me by my child's school.

_____ _____

Signature of Parent/Guardian **Date**

Sworn to before me this_____ day of _____

Notary Public Seal

You will be notified in writing of the outcome of this request. Please note that if your request for an exemption is denied, you may appeal the denial to the Commissioner of Education within thirty (30) days of the decision, pursuant to Education Law, Section 310.

SECTION BELOW FOR SCHOOL DISTRICT USE ONLY

To the Building Principal:

If, after review of the parental statement, questions remain about the existence of a sincerely held religious belief, Department of Health regulation [10 NYCRR, Section 66-1.3(d)] permits the principal to request supporting documents. Some examples include:

- A letter from an authorized representative of the church, temple, religious institution, etc. attended by the parent/guardian, literature from the church, temple, religious institution, etc. explaining doctrine/beliefs that prohibit immunization (Note: Parents/guardians need not necessarily be a member of an organized religion or religious institution to obtain a religious exemption);
- Other writings or sources upon which the parent/guardian relied in formulating religious beliefs that prohibit immunization;
- A copy of any parental/guardian statements to healthcare providers or school district officials in a district of prior residence explaining the religious basis for refusing immunization;
- Any documents or other information the parent/guardian may be willing to provide that reflect a sincerely held religious objection to immunization (for example: disclosure of whether parent/guardian or other children have been immunized, parent/guardian's current position on allowing himself or herself or his or her children to receive or refuse other kinds of medical treatment.)

Reviewer Name (Building Principal) _____

Indicate Result of Request Review:

APPROVED ☐ **Date of Approval**_____

DENIED ☐ **Date of Denial** _____

State Specifically Reason(s) for Denial:

_____

_____

_____

_____

_____

_____

You may attach additional sheets if necessary.

Reviewer Signature (Building Principal) _____

- Parent/guardian **must be notified in writing** of the approval or denial of the request. **If the request is denied, the notification letter must include the specific reason(s) for denial.**
- If a religious exemption request is denied, the parent/guardian may appeal the denial to the Commissioner of Education within thirty (30) days of the decision, pursuant to Education Law, Section 310.

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City School District of the City of Sherrill
5275 State Route 31, Verona, New York 13478-0128 • Tel. (315) 829-2520 • Fax (315) 829-4465

MR. ANDY BROWN
High School Principal
MRS. ERIN SANCHEZ
High School Assistant Principal
MRS. CARRIE HODKINSON
Middle School Principal

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian:

I request that my child _____(Date of birth: _____) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. Any medication Over the Counter must also be in the original container as well.

Signature(Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by the Private Healthcare Provider:

I request that my patient, as listed below, receive the following medication:

Name of Student _____DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Can this Student self-medicate and carry on self? Yes_____No _____

Healthcare Provider's Signature _____ Date:_____
Address: _____ Phone: _____

This medication order is valid for the current school year and summer school as needed.

J.D. George Elementary
5647 East Main Street
Verona, NY 13478
Phone (315) 829-7367
Fax (315) 361-5895

student photo here

Allergy Action Plan

(to be completed by physician)

Patient's Name:_____ **D.O.B**_____

Allergy To:_____

Asthmatic: Yes_____ **No**_____ ***If asthmatic, high risk for severe reaction**

Symptoms of an allergic reaction may include any/all of these:

Minor Reaction:

Skin: hives, itchy rash, and/or swelling about the face or extremities

*If symptoms are limited to skin, with no signs of a major reaction give Benadryl_____. Call parents or emergency contacts.

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation

Major Reaction:

Mouth: itching and swelling of lips, tongue, or mouth
Throat: itching and/or sense of tightness in the throat, hoarseness, and hacking cough
Lung: shortness of breath, repetitive coughing, and/or wheezing
Heart: "thready" pulse, "passing out"
Gut: nausea, abdominal cramps, vomiting, and/or diarrhea

If major reaction is suspected give EPIPEN_____.

(If EPIPEN administered Call rescue squad and parents or emergency contacts.)

Special Instructions_____

Physician Signature_____ **Date**_____

Physician Address_____ **Phone**_____

Parent/Guardian Signature_____ **Date**_____

Parent home #_____ **Cell #**_____ **Work #**_____

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

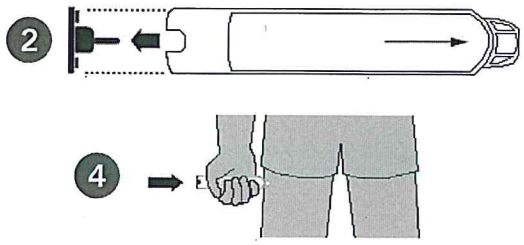
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

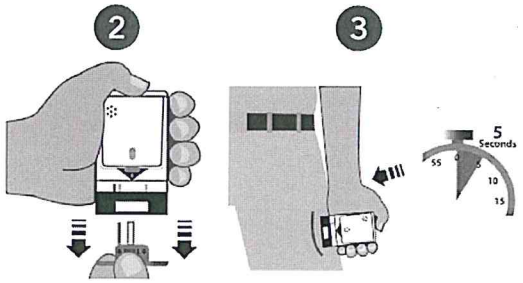
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

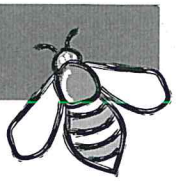
NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

Emergency Care Plan



BEE STING ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Severity of reaction(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly – it is important that treatment is give immediately.

Student Photo

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms

Benadryl ordered: ❑ Yes ❑ No Give _____ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: ❑ Yes ❑ No Special instructions: _____

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: _____

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ❑ Medication available on bus ❑ Medication NOT available on bus ❑ Does not ride bus

Special instructions: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed. Revised 1/08

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 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.

Emergency Care Plan

Sample

ASTHMA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthma Triggers: _____ Best Peak Flow: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, Peak Flow of < _____.
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", doesn't feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

Student Photo

SIGNS OF AN ASTHMA EMERGENCY:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment.
- Peak Flow of _____ or below.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

STAFF MEMBERS INSTRUCTED:

❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Stop activity immediately.
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.
Give medication as ordered: _____
Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.
Notify school nurse at _____ who will call parents/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

- Call 911 (Emergency Medical Services) and inform the that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually takes.
- A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed.

Revised 1/08

Sample

Emergency Care Plan

Name of Health Issue

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN EMERGENCY MAY INCLUDE ANY/ALL OF THESE:

- **Write symptoms here**
- **Write symptoms here**
- **Write symptoms here**

SIGNS OF AN EMERGENCY:

Student Photo

STAFF MEMBERS INSTRUCTED:

❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

STEPS TO FOLLOW FOR AN EMERGENCY:

•

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed.

Revised 1/08

Sample

Emergency Care Plan

DIABETES - HYPERGLYCEMIA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF A HYPERGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Gradual Onset
- Extreme thirst, very frequent urination, drowsiness
- Flushed skin, heavy breathing, blurred vision
- Vomiting, fruity or wine-like odor to breath

Student Photo

SEVERE SYMPTOMS INCLUDE:

- Stupor
- Unconsciousness

STAFF MEMBERS INSTRUCTED:

❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Stay with the student.
Notify school nurse immediately.
Call 911 to access Emergency Medical Services – transport to hospital by ambulance
Preferred Hospital if transported: _____

Notify parents/guardian (do not delay treatment by calling – obtain treatment for student first).

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed..

Revised 1/08

Sample

Emergency Care Plan

DIABETES - HYPOGLYCEMIA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF A HYPOGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Shaking, fast heartbeat, sweating, anxiety, irritability
- Complaints of hunger, impaired vision, weakness or fatigue
- **Onset may be sudden and can progress to Insulin Shock**

Student Photo

SEVERE SYMPTOMS INCLUDE:

- Appears very pale, feels faint, loss of consciousness
- Seizure activity

STAFF MEMBERS INSTRUCTED:

❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Stop any activity immediately.
Accompany the student to the Health Office. Notify school nurse immediately.
If off school grounds, provide a source of glucose:
- ½ - ¾ cup juice
- Glucose tabs
- Hard candy
- Regular soda (not diet!)
- Glucose gel

Notify parents/guardian (do not delay treatment by calling – treat or obtain treatment for student first).

STEPS TO FOLLOW FOR A HYPOGLYCEMIC EMERGENCY:

Glucagon ordered: ❑ Yes ❑ No
If Glucagon is ordered, it should be given by a willing volunteer who has been trained by the school nurse if student is unconscious, unresponsive or having a seizure.
After Glucagon is given, call 911. Notify parents Preferred Hospital if transported: _____
Students receiving glucagon without their parent or guardian present should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed..

Revised 1/08

School District Name

SEIZURE DISORDER – Emergency Care Plan

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF A SEIZURE EPISODE MAY INCLUDE ANY/ALL OF THESE:

☐ **Tonic-Clonic Seizure**: Symptoms may include an aura, muscle rigidity, followed by violent muscle contractions, loss of alertness (consciousness), biting the cheek or tongue, clenched teeth or jaw, loss of bladder or bowel control, difficulty breathing, blue skin color.

☐ **Simple Focal Seizure:** The person will remain conscious but experience unusual feelings or sensations that can take many forms, may experience sudden and unexplainable feelings of joy, anger, sadness, or nausea. He/she also may hear, smell, taste, see, or feel things that are not real.

☐ **Complex Focal Seizure:** The person has a change in or loss of consciousness. His or her consciousness may be altered, producing a dreamlike experience. People having a complex focal seizure may display strange, repetitious behaviors such as blinks, twitches, mouth movements, or even walking in a circle. These repetitious movements are called *automatisms*. More complicated actions, which may seem purposeful, can also occur involuntarily. Patients may also continue activities they started before the seizure began, such as washing dishes in a repetitive, unproductive fashion. These seizures usually last just a few seconds.

☐ **Absence**: Symptoms may be brief lasting only a few seconds and occur several times a day. During the seizure the person may: stop walking and start again a few seconds later, stop talking in mid-sentence and start again a few seconds later. Specific symptoms of typical petit mal seizures may include: changes in muscle activity (hand fumbling, fluttering eyelids, lip smacking, chewing), change in alertness (staring and lack of awareness)

STAFF MEMBERS INSTRUCTED:
☐ Classroom Teacher(s) ☐ Special Area Teacher(s)
☐ Administration ☐ Support Staff ☐ Transportation Staff

TREATMENT:
Clear the area around the student to avoid injury. DO NOT PUT ANYTHING IN THE STUDENT'S MOUTH
Place student on side if possible, speak to student in reassuring tone. Stay with student until help arrives

☐ Emergency Medical Services (911) should be called, student transported to hospital
Preferred Hospital if transported: _____
☐ **Emergency medication to be given by Nurse at onset of seizure**
☐ Student should be allowed to rest following seizure, call parent

Transportation Plan: ☐ Medication available on bus ☐ Medication NOT available on bus ☐ Does not ride bus
Special instructions: _____

Healthcare Provider Signature: _____ Date:_____Phone: _____

Written by: _____ Date: _____
☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

CONCUSSION MANAGEMENT PROTOCOL EXPLANATION

rev. 06/10/09

The following protocol has been established in accordance to the National Federation of State High School Associations and the International Conference on Concussion in Sport, Prague 2004. In addition, it has been fabricated in a collaborative effort with your school's medical and administrative staff, concussive experts in the Central New York area, and the Slocum Dickson Sports Medicine staff. It is imperative to keep in mind the safety of the student is the primary concern of Slocum Dickson Sports Medicine and your school district's personnel.

The information contained below is to be used as mere guidelines that are to be implemented in the time following a concussive event. The information is *not to be considered as all inclusive or all encompassing*.

When a student shows ANY signs or symptoms of a concussion:

- The Student **will not** be allowed to return to play in the current game or practice.
- The Student should not be left alone, and regular monitoring for deterioration is essential over the initial few hours following injury.

Following the initial injury, the Student **must** complete these steps:

- Follow up with their primary care physician or Emergency Department within the first 24 hours (Doctor Visit One). The Student **must have** the initial Physician Evaluation filled out completely, signed and dated when reporting to the School Concussion Management Team (CMT) Leader.
- Follow up with their primary care physician when asymptomatic (or a concussion specialist if there is a history of previous concussion or if post concussion symptoms last more than seven days) to be cleared to begin the Return to Play Protocol (Doctor Visit Two). The Student **must have** the second Physician Evaluation filled out completely, signed and dated when reporting to the School CMT Leader.
- Return to play **must follow** a medically supervised process, including clearance by a physician (Doctor Visit Three) before step five, "Full contact training in practice setting." The Student **must have** the Third Doctor Visit filled out completely, signed and dated when reporting to the School CMT Leader.

****Final clearance is at the discretion of the School Physician or Chief Medical Officer even if the player is cleared by another physician.****

CONCUSSION CHECKLIST

Name:_____ Age:_____ Grade:_____ Sport:_____

Date of Injury: _____ Time of Injury: _____Location of Event: _____

History

Has the athlete ever had a concussion? Yes No

*(If yes, indicate date, severity, and treatment received)*_____

_____

_____

Was there a loss of consciousness? Yes No Unclear

*(If yes, how long?)*_____

On Site Evaluation

Description of Injury:_____

_____

_____

Symptoms observed at time of injury:

Dizziness	Yes	No	Headache	Yes	No
Ringing in Ears	Yes	No	Nausea/Vomiting	Yes	No
Drowsy/Sleepy	Yes	No	Fatigue/Low Energy	Yes	No
"Don't Feel Right"	Yes	No	Feeling "Dazed"	Yes	No
Seizure	Yes	No	Poor Balance/Coord.	Yes	No
Memory Problems	Yes	No	Loss of Orientation	Yes	No
Blurred Vision	Yes	No	Sensitivity to Light	Yes	No
Vacant Stare/ Glassy Eyed	Yes	No	Sensitivity to Noise	Yes	No

* Please circle yes or no for each symptom listed above.

Does he/she remember the injury? Yes No Unclear

Does he/she have confusion after the injury? Yes No Unclear

Other Findings/Comments:_____

_____

Final Action Taken: Student Released to Parents / Student Sent to Hospital-Parents Notified

Evaluator's Signature:_____Title:_____

Address:_____Date:_____Phone No.:_____

PHYSICIAN EVALUATION

Date of First Evaluation:_____ **Time of Evaluation:**_____

Date of Second Evaluation:_____ **Time of Evaluation:**_____

Symptoms Observed:	**First Doctor Visit**		**Second Doctor Visit**	
Dizziness	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Tinnitus	Yes	No	Yes	No
Nausea	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Drowsy/Sleepy	Yes	No	Yes	No
Sensitivity to Light	Yes	No	Yes	No
Sensitivity to Noise	Yes	No	Yes	No
Anterograde Amnesia *(after impact)*	Yes	No	N/A	N/A
Retrograde Amnesia *(backwards in time from impact)*	Yes	No	N/A	N/A

* Please indicate yes or no in your respective columns. First Doctor use column 1 and second Doctor use column 2.

First Doctor Visit:
Did the athlete sustain a concussion? (**Yes** or **No**) (one or the other must be circled)
Additional Findings/Comments:_____
_____
Recommendations/Limitations:_____
_____

Signature:_____ Date:_____

Print or stamp name:_____ Phone number:_____
_____

Second Doctor Visit:
***** Athlete must be completely symptom free for 72 hours (3 days) in order to begin the return to play progression.**
Please check one of the following:

- ☐ Athlete is asymptomatic and is ready to begin the return to play progression.
- ☐ Athlete is still symptomatic more than seven days after injury and must be referred to a concussion specialist.

Signature:_____ Date:_____

Print or stamp name:_____ Phone number:_____

RETURN TO PLAY PROTOCOL

- ✓ The cornerstone of proper concussion management is rest until all symptoms resolve and then a graded program of exertion before return to sport.
- ✓ The program is broken down into six steps in which only one step is covered per day.
- ✓ If any concussion symptoms recur, the athlete should drop back to the previous level and try to progress after 24 hours of rest.
- ✓ In addition, the student should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

Date	Activity	CMT Leader Initials
_____	1. No exertional activity until asymptomatic for 72 hrs (3 days).	_____
_____	2. Light aerobic exercise such as walking or stationary bike, etc. No resistance training.	_____
_____	3. Sport specific exercise such as skating, running, shooting, etc. Progressive addition of resistance training may begin.	_____
_____	4. Non-contact training/skill drills.	_____
_____	5. Full contact training in practice setting. (medical clearance required)	_____
_____	6. Return to competition	_____

Third Doctor Visit:
(Please check one of the following)

Athlete is ☐ cleared ☐ not cleared for "Full contact training in practice setting" and "Return to competition" if symptoms do not return.

Additional Findings/Comments:_____
_____

Recommendations/Limitations:_____
_____

Signature:_____ Date:_____
Print or stamp name:_____Phone number:_____

CMT Leader Follow-up: (Please check all of the following that apply)

- ☐ Athlete has successfully completed Return to Play Protocol.
- ☐ Doctor #2 has been contacted and updated with this information.
- ☐ Doctor #2 has verbally cleared the athlete to return to competition.

Additional Comments:_____
_____
_____

Signature:_____ Date:_____
Print or stamp name:_____Phone number:_____

AT-17
Rev. 5/10

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
ALBANY, NY 12234

APPLICATION FOR EMPLOYMENT CERTIFICATE

See reverse side of this form for information concerning employment of minors.

All signatures must be handwritten in ink, and applicant must appear in person before the certifying official.

THIS APPLICATION DOES NOT AUTHORIZE EMPLOYMENT

PART I – Parental Consent – (To be completed by applicant and parent or guardian)

Parent or guardian must appear at the school or issuing center to sign the application for the first certificate for full-time employment, unless the minor is a graduate of a four-year high school and presents evidence thereof. For all other certificates, the parent or guardian must sign the application, but need not appear in person to do so.

Date.....

I, ... Age .....
[Applicant]

Home Address ....., apply for a certificate as checked below
[Full Home Address including Zip Code]

- ☐ Nonfactory Employment Certificate – Valid for lawful employment of a minor 14 or 15 years of age enrolled in day school when attendance is not required.
- ☐ Student General Employment Certificate – Valid for lawful employment of a minor 16 or 17 years of age enrolled in day school when attendance is not required.
- ☐ Full-Time Employment Certificate – Valid for lawful employment of a minor 16 or 17 years of age who is not attending day school.

I hereby consent to the required examination and employment certification as indicated above.

.....
[Signature of Parent or Guardian]

PART II – Evidence of Age – (To be completed by issuing official only)

..... – Check evidence of age accepted – Document # (if any) .....
[Date of Birth]

Birth Certificate State Issued Photo I.D Driver's License Schooling Record Other.....
[Specify]

PART III – Certificate of Physical Fitness

Applicant shall present documentation of physical exam from a school or private physician, physician's assistant or nurse practitioner licensed to practice within New York State. Said examination must have been given within 12 months prior to issuance of the employment certificate. Date of physical exam on file with school ..... If physical exam is over 12 months, provide student with certificate of physical fitness to be completed by school medical director or private health care provider.

If the physical exam or Certificate of Physical Fitness is limited with regards to allowed work/activity, the issuing official shall issue a Limited Employment Certificate (valid for a period not to exceed 6 months unless the limitation noted by the physician is permanent, then the certificate will remain valid until the minor changes jobs. Enter the limitation on the employment certificate. THE PHYSICIAN'S CERTIFICATION SHOULD BE RETURNED TO THE APPLICANT.

PART IV – Pledge of Employment – (To be completed by prospective employer)

Part IV must be completed only for: (a) a minor with a medical limitation; and (b) for a minor 16 years of age or legally able to withdraw from school, according to Section 3205 of the Education Law, and must show proof of having a job.

The undersigned will employ ..... residing at .....
[Applicant]

as ..... at .....
[Description of Applicant's Work] [Job Location]

for ..... days per week ..... hours per day, beginning ..... a.m. ..... p.m.

..... Factory ending..... a.m. .....p.m.
[Name of Firm]

Nonfactory .....
[Address of Firm]

..... Starting date ....
[Telephone Number] [Signature of Employer]

PART V – Schooling Record – (To be completed by school official)

Part V must be completed only for a minor 16 years of age who is leaving school and resides in a district (New York City and Buffalo) which require a minor 16 years of age to attend school, according to Section 3205 of the Education Law.

I certify that the records of ....
[Name of School] [Address]

Show that ..... whose date of birth is .....
[Name of Applicant]

Is in grade..... .....
[Signature of Principal of Designee]

PART VI – Employment Certification – (To be completed by issuing official only)

Certificate Number ..... Date Issued .....

....
[School or Issuing Center] [Address] [Signature of Issuing Officer]

GENERAL INFORMATION

An employment Certificate (Student Nonfactory, Student General, or Full Time) may be used for an unlimited number of successive job placements in lawful employment permitted by the particular type of certificate.

A Nonfactory Employment Certificate is valid for 2 years from the date of issuance or until the student turns 16 years old, with the exception of a Limited Employment Certificate. A Limited Employment Certificate is valid for a maximum of 6 months unless the limitation noted by the physician is permanent, then the certificate will remain valid until the minor changes job. It may be accepted only by the employer indicated on the certificate.

A new Certificate of Physical Fitness is required when applying for a different type of employment certificate, if more than 12 months have elapsed since the previous physical for employment.

An employer shall retain the certificate on file for the duration of the minor's employment. Upon termination of employment, or expiration of the employment certificate's period of validity, the certificate shall be returned to the minor. A certificate may be revoked by school district authorities for cause.

A minor employed as a Newspaper Carrier, Street Trades Worker, Farmworker, or Child Model, must obtain the Special Occupational Permit required.

A minor 14 years of age and over may be employed as a caddy, babysitter, or in casual employment consisting of yard work and household chores when not required to attend school. Employment certification for such employment is not mandatory.

An employer of a minor in an occupation which does not require employment certification should request a Certificate of Age.

PROHIBITED EMPLOYMENT

Minors 14 and 15 years may not be employed in, or in connection with a factory (except in delivery and clerical employment in an enclosed office thereof), or in certain hazardous occupations such as: construction work; helper on a motor vehicle; operation of washing, grinding, cutting, slicing, pressing or mixing machinery in any establishment; painting or exterior cleaning in connection with the maintenance of a building or structure; and others listed in Section 133 of the New York State Labor Law.

Minors 16 and 17 years of age may not be employed in certain hazardous occupations such as: construction worker; helper on a motor vehicle, the operation of various kinds of power-driver machinery; and others listed in Section 133 of the New York State Labor Law.

HOURS OF EMPLOYMENT

Minors may not be employed during the hours they are required to attend school.

Minors 14 and 15 years of age may not be employed in any occupation (except farmwork and delivering, or selling and delivering newspapers):

When school is in session:

- more than 3 hours on any school day, more than 8 hours on a nonschool day, more than 6 days in any week, for a maximum of 18 hours per week, or a maximum of 23 hours per week if enrolled in a supervised work study program approved by the Commissioner.
- after 7 p.m. or before 7 a.m.

When school is not in session:

- more than 8 hours on any day, 6 days in any week, for a maximum of 40 hours per week.
- after 9 p.m. or before 7 a.m.

This certificate is not valid for work associated with newspaper carrier, agriculture or modeling.

Minors 16 and 17 years of age may not be employed: --

When school is in session:

- more than 4 hours on days preceding school days; more than 8 hours on days not preceding school days (Friday, Saturday, Sunday and holidays), 6 days in any week, for a maximum of 28 hours per week.
- between 10 p.m. and 12 midnight <u>on days followed by a school day</u> without written consent of parent of guardian <u>and</u> a certificate of satisfactory academic standing from the minor's school (to be validated at the end of each marking period).
- between 10 p.m. and 12 midnight <u>on days not followed by a school day</u> without written consent of parent or guardian.

When school is not in session:

- more than 8 hours on any day, 6 days in any week, for a maximum of 48 hours per week.

EDUCATION LAW, SECTION 3233

"Any person who knowingly makes a false statement in or in relation to any application made for an employment certificate or permit as to any matter by this chapter to appear in any affidavit, record, transcript, certificate or permit therein provided for, is guilty of a misdemeanor."

2014-15 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 for Immunization Practices (ACIP).
This schedule reflects the minimum doses that are required for grades kindergarten through 12. Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. See footnotes for specific information for **each** vaccine.

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

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten	Grades 1 through 5	Grade 6	Grades 7 through 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)[2]	**4 doses**	**4 to 5 doses** (See footnote 2b)	**4 to 5 doses** (See footnote 2b-e)	**3 doses** (See footnote 2c-e)	**3 doses** (See footnote 2d-e)
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3] (Required only for students enrolling in grades 6-12 who have not previously received a Tdap at 7 years of age or older)	Not applicable	Not applicable	Not applicable	**1 dose** (See footnote 3b)	**1 dose** (See footnote 3b)
Polio vaccine (IPV/OPV)[4]	**3 doses**	**3 to 5 doses** (See footnote 4b-d)	**3 doses**	**3 to 5 doses** (See footnote 4b-d)	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**1 dose**	**2 doses** 2 doses required by age 7	**2 doses**	**2 doses**
Hepatitis B vaccine[6]	**3 doses**	**3 doses**	**3 doses**	**3 doses**	**3 doses**
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Haemophilus influenzae type b conjugate vaccine (Hib)[8]	**1 to 4 doses** (See footnote 8a-g)	Not applicable	Not applicable	Not applicable	Not applicable
Pneumococcal Conjugate vaccine (PCV)[9]	**1 to 4 doses** (See footnote 9a-f)	Not applicable	Not applicable	Not applicable	Not applicable

Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through18 months, and 4 through 6 years. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not necessary.
   c. For children born prior to 1/1/2005, doses of DT and Td meet the immunization requirement for diphtheria toxoid-containing vaccine.
   d. Children ages 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. For these children, the required 6th grade adolescent Tdap vaccine should not also be given.
   e. For previously unvaccinated children 7 years of age and older, the immunization requirement is 3 doses. Tdap should be given for the first dose, followed by 2 doses of Td in accordance with the ACIP-recommended immunization schedule for persons 0-18 years of age.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Tdap can be received regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
   b. For children enrolling in grades 6 through 12 who received a dose of Tdap at 7 years of age or older, the booster dose of Tdap is not required.

4. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at ages 2, 4, 6 through 18 months, with a booster at age 4 through 6 years. The final dose in the series should be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If 4 or more doses were administered before age 4 years, an additional dose should be received on or after age 4 years.
   c. If both OPV and IPV were administered as part of a series, a total of 4 doses should be received, regardless of the child's current age.
   d. For children 4 years of age or older who have previously received less than 3 doses, a total of 3 doses are required if the third dose is administered at age 4 years or older and at least 6 months after the previous dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)
   a. The first dose of MMR vaccine should be received at age 12 through 15 months, and the second dose at age 4 through 6 years. The second dose may be received before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   b. Students 7 years of age and older must have 2 doses of measles-containing vaccine, 2 doses of mumps-containing vaccine and at least 1 dose of rubella-containing vaccine.

6. Hepatitis B vaccine
   a. For children in grades 7 through 12, either 3 doses of pediatric hepatitis B vaccine or 2 doses of adult hepatitis B vaccine (Recombivax), administered at least 4 months apart are required (applies only to children 11 through 15 years old).
   b. Administration of a total of 4 doses of hepatitis B vaccine may be necessary when a combination vaccine containing hepatitis B is administered after the birth dose resulting in an inadequate interval between doses.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The ACIP routinely recommends that the first dose of varicella vaccine should be received at age 12 through 15 months and the second dose at age 4 through 6 years. The second dose may be received before age 4 years, provided at least 3 months have elapsed since the first dose. **NYS requires 2 doses of varicella vaccine for kindergarten entry.**
   b. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

8. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children who start the series on time should receive a Hib vaccine primary series and a booster dose to all infants. The primary series doses should be received at 2, 4, and 6 months of age. One booster dose should be received at age 12 through 15 months.
   b. If the first dose was administered at ages 7 through 11 months, a second dose should be received at least 4 weeks later and a final dose at 12 through 15 months of age.
   c. If 2 doses of vaccine were administered at 11 months of age or younger, a third and final dose should be received at 12 through 15 months of age and at least 8 weeks after the second dose.
   d. If dose 1 was administered at ages 12 through 14 months, a final dose should be received at least 8 weeks after dose 1.
   e. For children who received 1 dose of vaccine at 15 months of age or older, no further doses are necessary.
   f. For unvaccinated children 15 months of age or older, 1 dose of vaccine is required.
   g. Hib vaccine is not routinely required for children 5 years of age or older.

9. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of PCV13 vaccine at ages 2, 4, 6 months with a booster at age 12 through 15 months.
   b. Unvaccinated children 7 through 11 months of age should receive 2 doses, at least 4 weeks apart, followed by a 3rd dose at age 12 through 15 months.
   c. Unvaccinated children 12 through 23 months of age should receive 2 doses of vaccine at least 8 weeks apart.
   d. Previously unvaccinated children 24 through 59 months of age should receive only 1 dose.
   e. PCV13 is the preferred vaccine for use in healthy unvaccinated/partially vaccinated children 2 through 59 months of age. A single supplemental dose of PCV13 is recommended for children 14 through 59 months who have already completed the age appropriate series of PCV7. (Note: PCV13 has been licensed and recommended for children in the U.S. since 2/2010. PCV13 replaced the previous version of Prevnar, known as PCV7, which included 7 pneumococcal serotypes.)
   f. For further information, refer to the PCV chart available at http://www.health.ny.gov/prevention/immunization/schools/.

For further information contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433.

New York State law requires the following screenings for all students entering the school district for the first time and when entering Pre-K or K, 2nd, 4th, 7th, and 10th grade.

Vision

- Distance acuity for all newly entering students and students in Kindergarten, Grades 1, 2, 3, 5, 7 and 10.
- Near vision acuity and color perception screening for all newly entering students.

Hearing

- Hearing screening for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7 and 10.

Scoliosis

- Scoliosis (spinal curvature) screening for all students in Grades 5 – 9.

Health Appraisals

- A physical examination including Body Mass Index and Weight Status Category Information is required for all newly entering students and students in Pre-Kindergarten **or** Kindergarten, Grades 2, 4, 7 and 10.

Dental Certificates (Not required, yet recommended)

- A dental certificate is requested for all newly entering students and students in Kindergarten, Grades 2, 4, 7 and 10.

Immunizations

See NYS immunization schedule under school nurse forms

A letter will be sent home if there are any findings on the screening done at school that would cause concern or need medical follow-up. Please call the school's Health Office if you have any questions or concerns.