LONG ISLAND SCHOOL FOR THE GIFTED

MEDICAL FORMS PACKET ~ 2022/2023

All forms in this packet must be completed by the parent and/or physician.

1) **Physical Examination Form:** Education Law and Regulations of the Commissioner of Education require that a physical examination be done for all students when they enter the school district for the first time, and when they are in grades K, 1, 3, 5, 7 and 9. The physical examination form must be submitted to the school nurse no later than **October 1, 2022.**

2) **Immunizations:** All students must have up-to-date immunizations as required by the New York State Public Health Law, Section 2164. Schools will not permit a child to attend school unless the parent provides the school with a certificate of immunization or proof from a physician, nurse, practitioner, or physician's assistant that the child is in the progress of receiving the required immunizations. **Students cannot begin school until the school nurse receives the record of immunizations.**

   6th Graders: Additional required immunization for those entering grade 6:

   T dap

   7th Graders: Additional required immunization for those entering grade 7:

   Meningococcal ACWY Vaccine

   A record of your child's immunizations from your healthcare provider, health department or official copy of the immunization record from the child's previous school (a copy of the original immunization record from the healthcare provider – not a copy of the school health record) is acceptable. A NYSIIS/NYCIR record is also acceptable. The exact date of each immunization that was given must be included in the record.

3) **Health History Form:** This form is required each year and is completed by the parent/guardian. The form is a snapshot of your child's health and one that helps the nurse stay up to date on any medical changes your child has experienced during the year.

4) **Food Allergy Medication Form:** Please read through the Guidelines Regarding Medication in School. To hold medications at school for food related allergies, please make sure the following forms are completed:
   - **Food Allergy Health Form** (parent/guardian to complete)
   - **Food Allergy Action Plan** (parent/guardian and physician to complete)
   - **Medication Order** (parent/guardian complete Part A; physician complete Part B)

No medicine (including over the counter medications or creams) can be administered without a physician's order.

5) **Non-Food Allergy Medication Forms:** Please read the Guidelines Regarding Medication in School. To hold medications at school not related to food allergies, please make sure the following form is completed:
   - **Medication Order** (parent/guardian complete Part A; physician complete Part B)

No medicine will be self-carried or administered at school without a physician's order.

6) **Dental Form:** It is recommended that your child have a complete dental examination for grades K, 1, 3, 5, 7, 9 and 11. Please have your dentist complete and return to the school nurse by **October 1, 2022.**

Should you have any questions, please contact our school nurse, Kate Lombardi, RN, BSN.

klombardi@lisg.org

631.423.3557

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:

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 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, 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.

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www.lisg.org

Carol Yilmaz, Founder
Patricia Geyer, Ed.D., Head of School

HEALTH HISTORY FORM

Child's Name _____ Sex: _____

Date of Birth _____ Place of Birth _____

Address _____

Telephone _____

Father's Name _____ Work Phone _____

Mother's Name _____ Work Phone _____

Medical Provider Name: _____ Telephone _____

Birth/Delivery History _____

_____

Please check Yes or No for each of the following:

	Yes	No		Yes	No		Yes	No
Allergies	[ ]	[ ]	Diabetes	[ ]	[ ]	Kidney Problems	[ ]	[ ]
Anemia	[ ]	[ ]	Ear Infections	[ ]	[ ]	Pneumonia	[ ]	[ ]
Arthritis	[ ]	[ ]	Eye Problems	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]
Asthma	[ ]	[ ]	Fifth Disease	[ ]	[ ]	Scarlet Fever	[ ]	[ ]
Chicken Pox	[ ]	[ ]	Hearing Problems	[ ]	[ ]	Seizures	[ ]	[ ]
Congenital Defects	[ ]	[ ]	Heart Condition	[ ]	[ ]	Surgery	[ ]	[ ]
						Tuberculosis	[ ]	[ ]

If you checked Yes to any of the above, give details:

_____

_____

_____

Does your child receive any medication on a regular basis? NO____ YES____
If you answered Yes, give details: _____

_____

_____

_____ _____

Signature of Parent/Guardian Date

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Mrs. Carol Yilmaz, Founder
Dr. Patricia Geyer, Head of School

HEALTH HISTORY
Caring for Students with Food Allergies

Student Name: _____ Date of Birth: _____ Grade: _____

Primary Health Concern: _____

Secondary Health Concern(s): _____

Healthcare Provider's Name: _____ Phone: _____

Diagnosis (note specific allergens): _____

At what age was the student diagnosed with a food allergy? _____

What symptoms led to the diagnosis? _____

Approximately how many allergic reactions has the student experienced? _____

When was his/her last allergic reaction? _____

Has the child been hospitalized as a result of an allergic reaction? ❑ Yes How many times? _____

❑ No

Does the child have an early awareness of the onset of an allergic reaction? _____

What treatment does the child usually require for an allergic reaction? _____

Has the student experienced an allergic reaction at school before? _____

If so, please describe incident: _____

Does the student have asthma?: ❑ Yes ❑ No (Asthma can increase the severity of a reaction)

Is there anything else that the school should know to take the best care we can of your student?

_____

_____

_____

All school health information is handled in a respectful and confidential manner. May the school health office staff share this information with school staff on a "need to know" basis? ❑ Yes ❑ No

Parent/Guardian Signature _____ Date _____

Food Allergy Action Plan

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
▪ If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
▪ Other †	_____	☐ EpiPen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.)_____
b. _____	1.)_____	2.)_____
c. _____	1.)_____	2.)_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

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MEDICATION ORDER

To be completed by parent or guardian:

A. I request that my child _____, grade _____, receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other assigned person, will administer the medication.

Signature (Parent or Guardian) _____

Address: _____

Telephone: (Home) _____ (Work/Cell) _____ Date: _____

To be completed by the licensed health care provider:

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to be Taken During School Hours: _____ Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

_____

Other Recommendations: _____

Name of Licensed Prescriber & Title (Please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

Kate Lombardi, RN
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Fax: (631) 423-4368

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DENTAL FORM

Our school has a health program that is designed to improve, protect and promote the health of the child. As part of this health program, we strongly urge all parents to have their children visit their dentist at least once a year for a dental examination and whatever treatment may be necessary. In the interest of better dental health, please have your child take this form to a dentist of your choice and return it to the school nurse.

REPORT OF DENTAL EXAMINATION

This is to certify that I have examined the teeth of:

Name _____
(Last Name) (First Name) (Grade)

_____
(School) (Home Room Teacher)

Please check one of the following statements:

____ All necessary dental treatment has been completed at this time.

____ Treatment is in progress.

____ No dental treatment is necessary at this time.

Further Recommendations:

_____

_____

_____

Dentist: _____
(Print and Sign Name)

Date: _____

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE'S OFFICE