LONG ISLAND SCHOOL FOR THE GIFTED

2024-2025
MEDICAL FORMS PACKET

LONG ISLAND SCHOOL FOR THE GIFTED

MEDICAL FORMS PACKET~ 2024-2025

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, 2024

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: Tdap

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.

Dental Form: It is recommended that your child have a complete dental examination for grades K, 1, 3, 5, 7, 9 & 11. Please have your dentist complete and return to the school nurse by October 1, 2024.

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

631.423.3557

LONG ISLAND SCHOOL FOR THE GIFTED

Guidelines Regarding Medication in School:

New York State Law requires that every medication (prescription and over the counter) dispensed by the school nurse during school hours, must be accompanied by an Administration of Medication Form (available from the school nurse), signed by the parent and the doctor. A written note indicating parent consent AND a dated doctor's order are also acceptable. No medication will be given out without this documentation.

Prescription medication must be in the original bottle issued by the pharmacist with the child's name, dosage, frequency, and duration. Over-the-counter medications must be in the original, sealed manufacturer's package with the student's name clearly labeled.

The parent or guardian must assume responsibility for notifying the nurse of any changes in medication or dosage. All medication must be delivered to the nurse and be picked up by an adult at the end of the school year. Medication must be renewed annually.

Students are expressly prohibited from carrying medication and self-administering any medication, including over-the-counter medications. There is a Self-Medication Release form available in the nurse's office. This form can be used for asthma inhalers and Epi Pens if both the parent and doctor agree that your child can carry and self-administer the medication. Cough drops are not permitted as they are a choking hazard.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ 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:	Affirmed Name (if applicable):	DOB:

SCREENINGS

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

Vision	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
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	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominic Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

☐ **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

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	IMMUNIZATIONS
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

LONG ISLAND SCHOOL FOR THE GIFTED

HEALTH HISTORY FORM

Child's Name ___________________________________ Sex: ______ Date of Birth __________________

Place of Birth ________________________________

Address ____

Telephone ______________________________

Father's Name _____________________ Work Phone ______________ Cell Phone _________________

Mother's Name _____________________ Work Phone ______________ Cell Phone _________________

Medical Provider Name: ____ Telephone ___________

Birth/Delivery History ____

Please write Y (YES) or N (NO) for each of the following:

___Allergies	___Ear Infections	___Rheumatic Fever
___Anemia	___Eye Problems	___Scarlet Fever
___Arthritis	___Fifth Disease	___Seizures
___Asthma	___Hearing Problems	___Surgery
___Chicken Pox	___Heart Condition	___Tuberculosis
___Congenital Defects	___Kidney Problems	
___Diabetes	___Pneumonia	

If you checked YES to any of the above, please explain:

____

____

____

Does your child receive any medication on a regular basis? YES___ NO___ If YES, please give details:

____

____

____

Parent Signature:____ Date:________________

LONG ISLAND SCHOOL FOR THE GIFTED

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? ____

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 child?

____

____

____

All school health information is handled in a respectful and confidential manner.

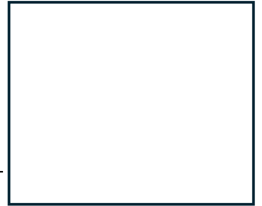
May the school health office staff share this information with school staff on a "need to know" basis?

____YES ____NO

Parent/Guardian Signature ____ Date _____________

FOOD ALLERGY ACTION PLAN

Place Child's Picture in Box



Student's Name:_______________________ D.O.B.:________ Teacher:________________

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 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 a Parent/Guardian cannot be reached, do not hesitate to medicate or take child to a medical facility!

Parent/Guardian Signature____ Date________________

Doctor's Signature (required)____ Date__________________

LONG ISLAND SCHOOL FOR THE GIFTED

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/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 (Print):____

Prescriber's Signature:____ Date:________________

Address:____

Phone:________________________________ Fax:______________________

Kate Lombardi, RN
klombardi@lisg.org
Fax: 631.423.4368

LONG ISLAND SCHOOL FOR THE GIFTED

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 take this form to your 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 ____ Grade:___________________
(Last Name) (First Name)

____
(SCHOOL) (HOMEROOM TEACHER)

Please check one of the following statements:

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

_____ Treatment in progress.

_____ No dental treatment is necessary at this time.

Further Recommendations:

____
____
____

Dentist Signature:____ Print Name:__________________

Date:________________________________

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE'S OFFICE

LONG ISLAND SCHOOL FOR THE GIFTED

SUNSCREEN CONSENT

To Be Completed by Parent – VALID FOR ONE YEAR

Student Name (PLEASE PRINT):____ Date of Birth:___________

Grade:__________ Homeroom Teacher:______________________________________

To reduce the possible overexposure to sun, NYS Education Law allows students who can apply or direct school staff members to apply FDA approved sunscreen products to carry and use them at school/school sponsored events **with written** parent/guardian consent.

My child **CAN** apply sunscreen by themselves or direct an adult to apply sunscreen for them.

Please check one:

____ I allow my child to apply his/her own FDA approved sunscreen, as needed.

____ I allow a directed adult to apply to my child, his/her own FDA approved sunscreen, as needed.

Parent/Guardian Signature and Contact Information

Name (PLEASE PRINT): ____ Date:_______________

Signature:____ Phone:________________

RETURN TO:

Mrs. Lombardi, RN BSN
631.423.3557
klombardi@lisg.org
Long Island School for the Gifted