

June 2016

Dear GCA Families,

As the 2015-2016 school year comes to a close, I would like to inform you of the Health Office requirements for the upcoming school year. New York State Education Department requires an annual physical exam for all new entrants, those students entering kindergarten and grades 2, 4 and 7. Please submit completed forms to the health office.

As of September 1, 2016 per New York Stated (NYS) Law, all 7th grade students MUST have proof of receiving a dose of the meningococcal vaccine in order to attend school. Without proof of receiving this vaccine students will not be allowed in school. Please refer to the accompanying flyer from the NYS Department of Health.

If you would like your child to receive *any* medication in school, please complete Part A of the attached form and have your Health Care Provider complete Part B. Please return the form to the Health office with a properly labeled, original bottle of medication. This applies to all over the counter (OTC) medications including Tylenol, Ibuprofen and cough drops, *as well as prescription medications*.

If you have any questions or concerns regarding any of these requirements for the 2016-2017 school year, please do not hesitate to contact me at 914-997-4194 or l.burke@gcaelem.net. Thank you for attention regarding these important matters.

Sincerely,

Lisa Burke, RN

Ess Durke, RN

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:		
Good Counsel Academy Elementary Gender: 🗓 N	T Q F Grade;		
IMMUNIZAT	IONS / HEALTH HISTORY		
☐ Immunization record attached ☐ No immunizations given today ☐ Immunizations given since last Health Appraisal:	Sickle Cell Screen: Positive PPD: Positive Elevated Lead: Yes	Negative 🗍 Negative 🗇 N	Not done Date:
Significant Medical/Surgical History: See attached			
Allergies:	☐ Insect:	Other:	
	IYSICAL EXAM		
Height: Weight:	·		
Body Mass Index:	Vision - without glasses/contact lense	s	Exam: Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L
☐ less than 5 th ☐ 5 th through 49 th ☐ 50 th through 84 th	Vision - Near Point	R	L
□ 85 th through 94 th □ 95 th through 98 th □ 99 th and higher	Hearing ☐ Pass 20 db sc both ears ô		L
Medications (list ail):	EDICATIONS listed on reverse of form Dosage/Time:		
Name:			
f AM dose is missed at home:		,	•
assess this student to be self-directed	student may self carry and self administe Please advise parent to send in additiona or if the moming medication has not bee	al medication in an given.	the event that emergency
Free from contagions & physically qualified for all physical of Limited contact: cheerlead, gymnastics, ski, volleyball, cross-contact: badminton, bowl, golf, swim, table tennis, tennis, and Specify medical accommodations needed for school:	education, sports, playground, work of untry, handball, fence, baseball, floor ho rchery, riflery, weight train, crew, dance,	school activ ckey, softball. , track, run, wa	ities OR only as checked:
Known or suspected disability:			Please monitor
Restrictions:			Please monitor
	goggles/impact resistant eyewear INFORMATION, if known	Other:	
pecify current diseases:		perlipidemia	Hypertension
rovider's Signature:	Phone:		(Stamp below)
rovider's Name/Address:	Fax:		
arent Signature:	Date:		

ALLERGY EMERGENCY MEDICAL PLAN

Name	D.O.B	Т	'eacher /class	Place Child's	
ALLERGY	ALLERGY TO:			Photo	
Asthmatic	Yes* □ No □ * Higher risk for severe rea	ction		Here	
	STEP 1: TREA	ATMENT			
Symptoms	<u>s:</u>	Give Checked Med **(To be determined by phys			
	od allergen has been ingested, or a bee sting curred but no symptoms:		□Epinephrine	□Antihistamine	
☐ Skin: c	cutaneous symptoms such as itching, flushing, or hives.	•	□Epinephrine	□Antihistamine	
	: Itching, tingling, or swelling of lips, tongue, mouth ar the face or extremities.	nd	□Epinephrine	□Antihistamine	
☐ Gut: Na	ausea, abdominal cramps, vomiting, diarrhea.		□Epinephrine	□Antihistamine	
☐ Throat:	† Tightening of throat, hoarseness, hacking cough.		□Epinephrine	□Antihistamine	
Lung:†	Shortness of breath, repetitive coughing, wheezing		□Epinephrine	□Antihistamine	
	Weak or thready pulse, low blood pressure, fainting, lueness.		□Epinephrine	□Antihistamine	
☐ If reac	ction is progressing (several of the above areas affected)	☐Epinephrine	□Antihistamine	
DOG! GE	†All of the above symptoms can prog	gress to a life-th	reatening reaction.		
DOSAGE				G 10 1 1 /G 10	
Antihistamine	Medication/dose/route	☐ Child is So	elf-directed Child ma	ay Self-admm/Self-car	
Epinephrine:	Medication/dose/route	☐ Child is Se	Child is Self-directed Child may Self-admin/Self-carr		
Name and Tit	tle of Licensed Prescriber (Please Print)				
Prescriber's S	Signature			Date	
	STEP 2: Emer	gency Calls			
l. Call 911 and	d request a paramedic with epinephrine. If ep	inephrine gi	ven, state that more is	s required.	
2. Emergency	Contact Information: Call Dr.	,	Phone:		
Parent/Guardia	an:	Phone:			
Alternate Cont	tact:	Phone:			
EVEN IF PAI	RENT/GUARDIAN CANNOT BE REACH HILD TO MEDICAL FACILITY!				
'arent/Guardia	an's Signature:	Date			
School Nurse	Signature:				

Good Counsel Academy Elementary

Valhalla

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PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL RELATED ACTIVITIES

A. To be completed by t	he Parent or	r Guardian:		
I request that my child		DOB	receive the	
medication as prescribed by our me in the properly labeled o	physician. Th	e medication is to	be furnished by	
Signature (Parent or Guardian)	•		ate:	
Telephone: Home	Cell	Work _		
B. To be completed by P	hysician:			
2		ed below, receive the following medication: DOB:		
Diagnosis:		-		
Medication:		Controlled Drug:	Yes No	
Dosage:	Time of	Administration:		
Begin Date: E1	nd Date:	-		
Specific Instructions:				
Possible Side Effects and Adver	rse Reactions:	• •	·	
Known Food or Drug Allergies:	Yes	<i>N</i> o		
If yes, please specify:		-	-	
Physician's Name (Please print):		ate:	
Physician's Signature:		·		
Address and Telephone Number	f.			

Newfor 2016-17 School Year

Parents:

All kids entering **7**th and **12**th **grade** must have the **meningococcal vaccine**.

Without it, they can't start school.

About the Vaccine:

- · It's not a new vaccine. It's been recommended for a decade.
- Most parents already choose to vaccinate their children.
- What's new is that the vaccine will be required for school entry as of Sept. 1, 2016.

About Meningococcal Disease:

- It causes bacterial meningitis and other serious diseases.
- · Teens and young adults are at greater risk.
- It comes on quickly and without warning.
- · Its symptoms are similar to the flu.
- Every case of this disease can result in death or long-term disability.

Check with your doctor. Even kids who have had a shot before may need a booster to start school.

