

Pocantico Hills Central School

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 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 _____

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

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): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses	R	L	Referral
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> 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: _____ (Stamp below)

Provider's Signature: _____ Phone: _____

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. 10/3/07



INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Student: _____ Age: _____

Grade (check): 6 7 8 Date of Birth: ____/____/____

Sport: _____

Date of last health appraisal: ____/____/____ Limitations: Yes No

PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it may require a review and approval by the school physician before the student can report to practice or tryouts.

HISTORY SINCE LAST HEALTH APPRAISAL:

- Allergies (Bee Sting/Medications/Food/Latex,etc.) Yes No
Does the student carry an Epi-pen® for a life-threatening allergy? Yes No
Asthma Yes No
Does the student carry an inhaler? Yes No
Concussion/Head injury/Seizures Yes No
Recent injury that requires medical attention or protective equipment? Yes No
Recent illness lasting longer than one week (ie. Mono) Yes No
Currently taking medications Yes No
Diabetes/Hypoglycemia Yes No
Heart/Blood Pressure Problems Yes No
Heat Exhaustion or Stroke Yes No
Hearing Impairment Yes No
Bleeding Tendency/Anemia Yes No
Recent Surgery or Hospitalization Yes No
Kidney/Liver Disease Yes No
Contact Lenses Yes No
Is there any medical condition that might be aggravated by playing sports? Yes No



PART C: TO BE COMPLETED BY PARENT OR GUARDIAN

Describe the condition or situation that caused any questions in PART B to be answered "YES".

PART D: PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ DATE: ____/____/____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART E: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation:

- Approved Referred to School Physician

Signed: _____ Date: ____/____/____

School Health Office

If referred to the School Physician:

- Requalified Disqualified

Signed: _____ Date: ____/____/____

School Physician

POCANTICO HILLS CENTRAL SCHOOL
599 Bedford Road
Sleepy Hollow, New York 10591
Telephone 914-631-2440
Fax 914-631-3280

**PARENT AND PHYSICIAN'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 _____ DOB _____ 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*. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

Signature(Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

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

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _____ Date: _____

Address: _____ Phone: _____

- * Medication must be in original pharmacy labeled container with specific orders and name of medication.
- * Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature: _____ Date: _____



Emergency Care Plan



ASTHMA

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

Asthma Triggers: _____ Best Peak Flow: _____

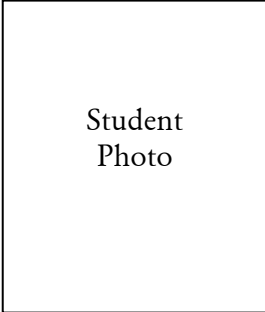
Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

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.



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:

Administration

Classroom Teacher(s)

Support Staff

Special Area Teacher(s)

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 Health Care Provider

Emergency Care Plan



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



Emergency Care Plan



FOOD ALLERGY

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

Asthmatic: Yes No (increased risk for severe reaction) Allergen(s): _____

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

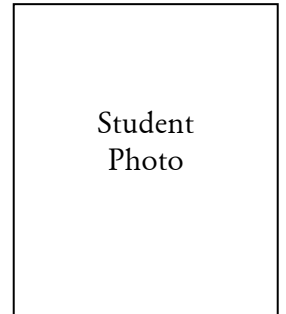
Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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

- **MOUTH** Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- **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.



STAFF MEMBERS INSTRUCTED:

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

TREATMENT: Rinse contact area with water if appropriate

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 INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS 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