AUBURN ENLARGED CITY SCHOOL DISTRICT
Universal Pre-Kindergarten and Kindergarten MEDICAL PACKET

This packet contains the following forms:

For your information . . . .

* Letter to Parents/Guardians from AECSD Nursing Supervisor
* District Medication Policy

To be completed by Parent/Guardian . . . .

* Pre-Kindergarten and Kindergarten Registration Health Form
* Health Insurance Coverage Form
* HIPPA Form

To be completed by Physician and Dentist and submitted by Parent/Guardian . . .

* Health Appraisal Form (Physical Form)
* Dental Health Certificate

IF YOUR CHILD IS REGISTERING FOR **UNIVERSAL PRE-KINDERGARTEN (3PK / UPK)**

Please complete the forms referred to above, and along with the items listed below, return to the District with your completed Enrollment and Registration Forms or at least ***prior to the first day of classes***:

Physical Exam
Proof of Lead Screening
Proof of Dental Screening

IF YOUR CHILD IS REGISTERING FOR **KINDERGARTEN**

Upon receipt of your completed Enrollment and Registration Forms, you will be supplied with information regarding the next step of the registration process, which involves a visit to your child's new school. ***You must present your completed Medical Packet to Health Services staff for review at that visit.***

The Medical Packet includes: the forms referred to above, along with the items listed below:

Physical Exam
Proof of Lead Screening
Proof of Dental Screening

Auburn
Enlarged City School District

Harriet Tubman
Administration Building

Office of Health Services

Dear Parents/Guardians of Pre-Kindergarten and Kindergarten Students:

Welcome to the beginning of an exciting adventure – the start of your child's formal education! New York State Public Health Law, Section 2164 mandates that schools shall not permit a child to be admitted to school, unless the parent provides the school with a certificate of immunization or proof from a physician that their child has been immunized. Immunizations must be documented and signed by a health care provider or health department. Baby books are no longer accepted as proof of vaccination. All documentation must specify the exact date each immunization was administered. Your child will not be permitted to attend school without the necessary verification of immunizations.

Most Pre-Kindergarten students will require additional vaccinations prior to the start of Kindergarten. Please contact your health care provider to make these arrangements.

In addition to vaccinations, New York State Law also requires the parent/guardian of any child entering a Pre-Kindergarten/Kindergarten program to provide the school district with a report of a medical examination, signed by a licensed health care provider and submitted using the enclosed physical exam form (no other format will be accepted). This exam must be current and not done more than twelve months prior to the commencement of the school year. Proof of lead testing and a dental health certificate containing a report of a comprehensive dental examination are also required.

Thank you for your attention in this matter. Have a wonderful school year!

Sincerely,

Caren Radell, RN
Supervisor of Nursing and Health Services

Updated: 12/19/2018

78 Thornton Avenue • Auburn, New York 13021 • Telephone: (315) 255-8829 • Fax: (315) 255-8855

AUBURN ENLARGED CITY SCHOOL DISTRICT

School Health Services

To: Parent/Guardian

From: School Health Services

Re: Administration of Medication in School

The policy for students receiving medication in school is as follows:

1. **NO MEDICATION WILL BE GIVEN IN SCHOOL WITHOUT A WRITTEN PHYSICIAN'S ORDER**. This order must include the student's name, name of medication, dosage, time and dates to be given. The label on the medicine bottle is not sufficient.

2. **A WRITTEN REQUEST FROM THE PARENT FOR THE SCHOOL HEALTH OFFICE TO ADMINISTER THE MEDICATION MUST BE PROVIDED.**

3. Medicine arriving in school in unmarked containers, baggies, etc., will not be given. The medication must be in its original container.

4. The medication should be delivered to the school by the parent/guardian.

5. Do not send aspirin or other single dose medication to school with your child. These medications will not be administered without fulfillment of the requirements stated above. **This also includes cough drops.**

6. The medication will be kept in the school health office throughout the time it is to be administered.

7. Parents will be contacted to make arrangements to pick up discontinued or unused medication.

8. Medications must be picked up at the end of the year or they will be discarded.

9. New physician orders for medication administration are required for each school year.

If, at any time, you have questions or concerns regarding the administration of medication, or this procedure, please contact your school health office.

Thank you for your cooperation.

Updated 10/2009

AUBURN ENLARGED CITY SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
Pre-Kindergarten and Kindergarten Registration Health Form

Student Last Name: _____ **Student First Name:** _____

Date of Birth: _____ **Place of Birth:** _____

Sex: M____ F____ Grade: ***(circle one)*** **3PK UPK K School:** _____

Student Address: _____

In case of accident or illness, it is mandatory that you provide the following information for emergency calls:

Name	Last	First	Address	Home/Cell Phone	Work Name	Work Phone
Mother						
Father						
Step Parent						
Step Parent						

List TWO persons (relatives/babysitter/neighbor) who will assume temporary care of your child if you cannot be reached:

Name	Relationship	Address	Home/Cell Phone	Work Name	Work Phone

Physician Name: _____ **Dentist Name:** _____

MEDICAL HISTORY

Has child, or any immediate family member (Parents/Grandparents) had a history of:

Diabetes _____
Heart Disease _____
Seizures _____
Sickle Cell Trait _____
Sudden Cardiac Death _____

Has child had: (Provide dates)

RSV _____ Scarlet Fever _____
Chicken Pox _____ Rheumatic Fever _____
Pneumonia _____ Pertussis _____

Surgery _____ Serious Injury _____
Broken Bones _____ Head Injury _____
Loss of Consciousness _____

Does child have any problem with:

Constipation _____ Diarrhea _____ Bedwetting _____
Frequent Urination _____ Is your child potty trained_____

Does child contract frequent: (More than 4-5 per year)

Sore Throats/Strep Infections _____

Earaches/Ear Infections _____ Under care of Dr. _____
Tubes in ears _____ Date of insertion _____
Skin Rashes/Eczema _____
Headaches _____ Stomachaches _____

Does child have:

Asthma/Wheezing _____
Under care of Dr. _____ Medication _____

Allergies: *(circle all that apply)* Food Insect bites Medications Other
Describe allergens/reactions: _____
Has child ever been stung by a bee? Yes ____ No ____
If yes, describe reaction: _____

Heart Murmur _____ Under care of Dr. _____

Seizure Disorder _____ Under care of Dr. _____
Medication _____ Date of last seizure _____

Vision Problems _____
Under care of Dr. _____ Glasses: Yes ____ No ____
Last appointment _____

Hearing Problems _____
Under care of Dr. _____ Hearing aids: Yes ____ No ____
Last appointment _____

Are there any other medical problems or concerns that the school should be aware of: _____
_____
_____

Does child take any medication on a regular basis? _____
_____

In case I cannot be reached, I authorize the Auburn School District to render such treatment as may be necessary in an emergency for the health of my child. I give my permission to the school official in charge to obtain the services of the nearest ambulance, rescue service, family physician on record, or other physician if my own is not available, to provide immediate and necessary care. This form will be utilized for the current school year. The information will be shared with appropriate instructional staff, the transportation department, and Health Services. It will also be available on field trips and in the event of an emergency will be given to emergency personnel.

Date: _____ **Signature of Parent/Guardian X _____**

* If any of the above information changes during the course of the school year, please notify the School Nurse, as soon as possible. ***NYS Education Law requires school districts to have on file signed instructions for emergencies from parents/guardians.***

For Office Use Only
*If **Kindergarten Registrant**, did parent/guardian provide:*

Physical Exam	___	Date of Exam:_____	___	Release of Information signed
Dental Certificate	___	Date of Exam: _____	___	Renewed-Received Emergency Action Plan (date: ____)
Immunizations	___	Up to date: _____	___	Reviewed and Received Medication Policy and Order Sheet
			___	Reviewed Immunizations, Physical and Dental requirements

Reviewed by: (Nurse) _____
Date of Interview/Form Completion: _____

Revised: 01/24/2017

RELEASE OF INFORMATION FORM TO ASSIST PARENTS IN OBTAINING HEALTH AND DENTAL INSURANCE COVERAGE FOR THEIR CHILDREN ATTENDING AUBURN ENLARGED CITY SCHOOL DISTRICT

The purpose of this release is to allow the Cayuga County Health and Human Services (CCHHS) Department, Auburn Enlarged City School District (AECSD), and the Booker T. Washington Center (BTW) to better assist you and your children to get and maintain health and dental coverage through the Public Insurance Program (Medicaid).

By signing this release you will be allowing CCHHS, AECSD, and BTW to share the confidential information listed below. This information may be further disclosed to the Cayuga County Health and Human Services Department and the local facilitated enrollers at BTW so they can also assist in ensuring your child(ren)'s uninterrupted coverage. A facilitated enroller is someone who can assist you to enroll in a health insurance plan or dental insurance coverage. **The information will only be shared to the extent that it is necessary or helpful to achieve this goal.**

The information disclosed will be limited to:

- My name and names of persons living in the household
- Dates of birth
- Address
- Phone number
- Gender
- Last four digits of Social Security Number for those applying for, or in receipt of Medicaid coverage
- Eligibility Status for Health and Dental Insurance, Temporary Assistance, Food Stamps, Day Care, HEAP Medicaid, including eligibility periods
- Status of School enrollment

Child's name: _____ SS# *_____ DOB _____ School _____
(last four digits)

Child's name: _____ SS# *_____ DOB _____ School _____
(last four digits)

Child's name: _____ SS# *_____ DOB _____ School _____
(last four digits)

My child(ren) currently has ***health*** insurance with _____
(*name of insurance company)*

My child(ren) currently has ***dental*** insurance with _____
(*name of insurance company)*

☐ My child(ren) have NO ***health*** insurance at this time. ☐ My child(ren) have NO ***dental*** insurance at this time.

RELEASE

I hereby give CCHHS, AECSD, and BTW permission to share the above information between themselves on my behalf. I also give permission for AECSD to share this information to CCHHS and BTW, only to the extent of helping me get or maintain health and dental coverage. I understand that any information released on my behalf may not be further disclosed without my express written permission.

I may revoke (cancel) this release at any time by writing to AECSD, Caren Radell, Nurse Supervisor, 78 Thornton Ave., Auburn, NY 13021. Such revocation will not affect any previous actions already taken.

_____ _____
(*Signature of Parent/Guardian or Student over 18)* *(Date)*

_____ _____
(*printed name)* *(relationship to student)*

_____ _____
(address) *(phone number)*

☐ I do not wish to participate in this insurance program.

*optional

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☒ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

PLEASE FILL OUT THE HIGHLIGHTED FIELDS ON BOTH PAGES

Name and address of facility/person disclosing HIV-related information: (Doctor/Facility)

Name of person whose information will be released: (Student)

Name and address of person signing this form (if other than above): (Parent/Guardian)

Relationship to person whose information will be released: _____

Describe information to be released: Medical

Reason for release of information: School accommodations

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any: _____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits
(Note: Federal privacy regulations may restrict some consequences): _____

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

Authorization for Release of Health Information and Confidential HIV-Related Information*

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

Auburn Enlarged City School District

78 Thornton Avenue, Auburn, New York 13021

Reason for release, if other than stated on page 1:

N/A

If information to be disclosed to this facility/person is limited, please specify:

N/A

Name and address of facility/person to be given general health and/or HIV-related information:

N/A

Reason for release, if other than stated on page 1:

N/A

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HgbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ 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

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Auburn Enlarged City School District

ADMINISTRATIVE OFFICES
78 Thornton Avenue, Auburn, N.Y. 13021-4698

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 visit to a dentist? ☐ 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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam 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 name and address (please print or stamp) Dentist'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):_____

III. 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.