Notre Dame-Bishop Gibbons School

2600 Albany Street · Schenectady, NY 12304-1899 · (518) 393-3131 · Fax (518) 370-3817

Dear Parents/Guardians,

I hope this letter finds you and your family well.

I have a few reminders from the health office. Per NYS and ND-BG policy, all students entering grades 7, 9 and 11, as well as all new ND-BG students (ALL 6th graders and new students), to have a current physical on file at the school. A current physical is also required for working papers and sports participation.
NYS Department of Health also has specific immunization requirements for School Entrance/Attendance. All students are required to have all vaccination. Additional requirements for grade 6-12 are as follows:

6th graders will require the T-dap vaccination (*must be given at age 10)

7th graders will require the first meningococcal vaccination

12th graders will require the second meningococcal vaccination (*only 1 dose is required if 1st dose was received after their 16th birthday)

Please be advised that, per NYS guidelines and ND-BG policy students are to be ***excluded** from attending school until all required vaccinations are administered and proper documentation is received.
For your convenience, I am sending a copy of a blank physical form, a parental permission form for the nurse to administer prescribed medications at school, and an as needed medication form for the doctor to fill out as appropriate (for example: Motrin or Tylenol as needed for pain).

Please feel free to contact the health office if you have any questions. Your children are truly a joy to care for.

Thank you in advance,

The Health Office
Ph: 518-393-3131 ext. 104

Fax: 518-370-3817

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	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
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	

Lead Level Required for PreK & K	Date
☐ Test Done ☐ Lead Elevated ≥5 μg/dL	

☐ **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

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Medication Policy

Students are not allowed to carry prescription or over-the counter medications (including cold medicine, Motrin, Tylenol, ect.) while at school without a doctor's order **and** parental consent. In an event that a student may need medication during the school day, please follow these guidelines (per New York State Law):

1. The nurse must receive a written order and instructions from the student's physician. This is required for both prescription medications and over the counter medications. The following information must be on the physicians' order: the name of the student, Date of Birth of the student, name of the medication, dosage of the medication, route of the medication and frequency of administration of the medication.

2. The nurse must also have written parental consent in order to administer the medication during school hours. Self-carry forms are available, if indicated for inhalers etc.

3. Prescription medication must be in the original container and should include students name, name of medication, dosage of medication, route of medication delivery, and frequency of administration of medication. If necessary, please ask your pharmacist for an additional container- one for home and one for school.

4. If you want to call your students physician and have an order at the school for an 'as needed' medication, this would be beneficial for both the student and yourself. You can simply call your physician's office and ask them to write an order (please have them include all necessary information- name, route, dosage and frequency of medication, and reason for medication) and have them fax it to the school. The 'as needed' medications that are commonly ordered are Tylenol or Motrin. I have also created a from that you can bring to your doctors office to have them complete. Once you receive that form, you can sign the parental consent section and then send it to the school via fax, email, mail, or have your student bring it to the health office.

5. Medication needs to brought in to the health office by the parent or a responsible adult.

6. **All** medication orders are only good for that current school year and must be renewed at the beginning of every school year.

All necessary forms are on the school website, or students can stop by my office to pick them up.
Please feel free to call if you have any questions.

Christine Goodwill, RN, BSN
ND-BG School Nurse
Ph# 518-393-3131 (ext. 104)
Fax# 518-370-3817

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Authorization for Administration of medication:

1. To be completed by the parent or legal guardian:

I, ________________________________, give parental consent that my child ______________________________ grade ______ may receive any and all medications that are prescribed by a licensed health care provider while at school by the school nurse.

Signature of parent/legal guardian: ______________________________
Contact information for parent'/legal guardian: ____________________
Today's date: __________

I, ________________________________, as parent or legal guardian of ____________________________, authorize the designation of specified school personnel at Notre-Dame- Bishop Gibbons, who are not licensed health care professionals, to supervise the administration of required medication, which is to be "self-directed" to my child:

Student name: ______________________________ Today's Date: __________
Name and dosage of medication: ____________________________
Route and frequency of medication: ____________________________
Signature of parent/legal guardian: ____________________________

Please return completed form to the health office. 😊

Thank you. Please call with any questions.

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Self Carry and Self Administer of Medication:

1. To be completed by the parent or legal guardian:

   I consent that my child ______________________________ grade ______ can self carry and self administer the medication as prescribed by a licensed health care provider. An adult will supervise my child taking his/her own medication (if self carry and self administer order are on file).

   Print Name (Parent or guardian): ________________________________

   Signature (Parent or guardian): __________________________________

   Address: ____

   Telephone: Home ___________________ Cell ________________________

   Date: ____

   Medication:_______________________ Dosage:___________________
   Route of medication: _________________ Frequency : _________________

2. The school requires a physician order that specifies that the student can self-carry and self- administer the medication. We need the name of the student, the name of the medication, the dose of the medication, frequency of administration, and route of administration.

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As Needed medication order and authorization:

1. **To be completed by physician:**

   Students name: ______________________________ DOB: ______________
   Name and dosage of medication: _____________________________________
   Route and frequency of medication: __________________________________
   Rationale for as needed (prn) medication: ____________________________
   Signature of ordering provider : ___________________________
   Printed name of ordering provider: ________________________
   Today's date: ____________ Contact #: ______________________

2. **To be completed by parent/legal guardian:**

   I, ________________________________, give parental consent that my child

______________________________ grade ______ may receive any and all medications that are prescribed by a licensed health care provider while at school by the school nurse.

Signature of parent/legal guardian: ___________________________________
Printed name of parent/legal guardian: ________________________________
Today's date : ______________ Contact # : _____________________

Please return completed form to the health office. 😊

Thank you. Please call with any questions.

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