

Middle school health screenings:

- Height and weight
- distance and near vision screening for grades 5 & 7
- Hearing screen for grades 5 & 7
- scoliosis for **all 5th and 7th grade girls** www.scoliosis.org

Color vision tests will be conducted on any student who has not already been screened.

• MEDICATIONS IN SCHOOL

The following procedure needs to be followed if your child should need medication in school:

- Medications must be transported to and from school by the parent/guardian(or other adult designee).
- Medications must be taken to the nurse's office, so that orders can be reviewed & parental signatures obtained. Please **DO NOT** send any medications in with your child or drop them off in the Main Office.
- Medication orders must be renewed each school year. Previous school year's orders for any medication will not be accepted.
- Medications must have a physician order and a note from the parent giving permission to give the medication to your child. **This also includes over-the-counter medications such as Tylenol, Ibuprofen, and cough drops.**
- Inhalers for asthma, and Epi-pens for allergies may be carried by your child with a written order from the physician and a note of permission to self-carry by the parent. It is advised that you keep an extra inhaler or Epi-pen in the Health Office for use if it is forgotten at home by your child.

*****All medications, including those to treat a life-threatening health condition (i.e. Epi-pen, insulin, glucagon), should have the appropriate medical paperwork on file in the Health Office. The health and safety of our students is taken very seriously, and we appreciate your cooperation with this matter.**

At the end of each school year, notices will be sent home in June, reminding parents/guardians that medications & supplies need to be picked up. Any medications not picked up at the end of a school year, must be disposed of per New York State Education Department and the Department of Environmental Conservation regulations. **NO MEDICATIONS WILL BE KEPT FROM SCHOOL YEAR TO SCHOOL YEAR.**

Please click on this link for medication form: <https://www.ktufsd.org/Page/443>

Physical Education Excuses

There may be times when it is medically necessary for your child to be excused from participating in Physical Education (injury, post-surgery etc.). Please understand that this is a medical issue as well as a PE issue. **All PE excuses from a health care provider should come to the nurse first.** A copy of the note will be made and given to your child's PE teacher.

If the initial note does not specify a date for your child to return to PE then you will need another note for him/ her to resume these activities.

No participation in PE activities during the school day also means no participation in any after school PE activity as well.

Parent notes to excuse a child for one day from PE due to asthma issues, a head cold, etc. may be directed to the PE teachers.

Modified and High School Sports Information:

Any 7th grade student academically eligible may sign up for modified and high school sports.

Each student must have a current physical exam on file in the school health office. **The physical exam must be dated no more than one year prior to the month the sport starts.**

The physical exam may be completed by your private health care provider or by the school nurse practitioner. For each sport, an update form must be filled out & signed by the parent/guardian and submitted to the Health Office **prior to try outs**. If a middle school student tries out for a high school sport, he/she will have to go for an athletic placement process (APP) test, along with providing a current physical. Dates, times, & location of the APP test can be found on the district website under "Athletics".

Please click on this link for sports forms: <https://www.ktufsd.org/Page/442>

Physical examinations are required for each **5th and 7th grade** student as well as any student, regardless of grade level, who are **new** to the Ken Ton School District. **All current 6th graders have forms mailed home in May to the addresses that you have on file for your child at school.** This form is to be filled out by your health care provider. **Please make sure you obtain a copy of your child's physical at the time of the visit.** Many clinics will charge you a fee if you need copies of forms filled out after your child's appointment.

Physicals are also required for participation in modified or high school sports. Please check under the **sports** tab on the left for further information.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$				

System Review and Abnormal Findings Listed Below

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:	DOB:
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SCREENINGS

Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes				
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

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

Student may participate in all activities without restrictions.

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 Age of First Menses (if applicable) : _____

Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

Order Form for Medication(s) Needed at School Attached

IMMUNIZATIONS

Record Attached Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: _____ Fax: _____

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