Dear Friends Academy Families

Welcome to the NEW SCHOOL YEAR from the Health Office

In preparation for your child's entry, we are writing to share some important information from the Health Office. **PLEASE READ CAREFULLY**, as we hope to help you avoid the hassle of having to upload forms multiple times. We have included a checklist at the end of this letter to help organize all of the requirements that are explained.

In addition some of the required documents are also attached in the end.

Friends Academy uses **Magnus Health**, the electronic storage system for our students' medical records, accessible via the FA Parent Portal. **New families will receive Parent Portal and Magnus Health login information in a separate email.**

ANNUAL PHYSICAL AND IMMUNIZATION RECORDS

NYS PHYSICAL EXAM FORM and an up-to-date IMMUNIZATION RECORD are required prior to your child's first day of school. We ask that all families upload the Physical and Immunization forms as soon as possible. Newly admitted students will not be allowed to start school until we receive these forms. Please note that we will accept any physical exam completed within the 12 months prior to the start of school. Going forward we will need the physical exam form to be **updated yearly from the date the exam was done.**

IMMUNIZATION REMINDERS FOR ALL STUDENTS:

Please see the attached **list of required vaccinations** organized by grade level. These immunization requirements are mandated by NYS for school entry and attendance. **Please refer to the requirements pertinent to your child's grade level.**

MEDICATION ADMINISTRATION:

If your child needs to take prescription or over-the-counter medication in school, **you must have your physician complete the Medication Permission Request Form, and also complete the parent signature portion.** Students are NOT allowed to carry medication (except approved inhalers or EpiPens) while in school. Please note,

medications that are to be kept in the nursing office **must be brought in by the parent**, **NOT the student,** and will NOT be accepted in the nursing office without the proper paperwork.

VITAL HEALTH RECORD AND OTHER HEALTH INFORMATION:

Parents must complete the online Vital Health Record in Magnus Health so we have important health history on file. This must be updated annually.

For students with specific health concerns, the following forms are available in Magnus Health to be completed by a healthcare provider and signed off by a parent.

- **Asthma Action Plan**
- **Food Allergy Action Plan**
- **Diabetes Action Plan**
- **Seizure Action Plan**

***ANY ACTION PLAN THAT INCLUDES MEDICATIONS MUST BE ACCOMPANIED BY A MEDICATION PERMISSION REQUEST FORM**

CONSENT TO TREAT:

Please complete, sign, and notarize the attached Authorization to Consent to Health Care. Once it is completed it must be uploaded into the Consent To Treat section of Magnus Health.

MIDDLE AND UPPER SCHOOL ATHLETES:

In addition to the Physical Exam and Immunization record any student in grades 7-12 participating in athletics MUST have additional forms completed such as **Athletic Consent, Concussion Fact Sheet** and **Interim Form** PRIOR TO THEIR FIRST PRACTICE OR THEY WILL NOT BE ALLOWED TO PRACTICE: You will receive a separate email form the Athletic Department with the link to sign up for a sport and to fill out athletic forms.

If you have any questions, please feel free to contact us. We are more than happy to discuss any questions you may have that are specific to your child's health.

Sincerely,
Daisy Baldwin, RN

daisy_baldwin@fa.org

(516) 254 3487

CHECK LIST - ITEMS THAT MUST BE UPLOADED INTO MAGNUS HEALTH:

- **ANNUAL PHYSICAL EXAM (including height, weight, blood pressure & pulse)**
- **VACCINATION RECORD**
- **CONSENT TO TREAT**
- **MEDICATION PERMISSION REQUEST FORM ***
- **ASTHMA ACTION PLAN ***
- **FOOD ALLERGY ACTION PLAN***
- **ANY ALLERGY ACTION PLAN ***
- **DIABETES ACTION PLAN ***
- **SEIZURE ACTION PLAN ***

ADDITIONAL REQUIREMENTS:

COMPLETE VITAL HEALTH RECORD
ATHLETIC FORMS *

***only if applicable**

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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ 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 Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ 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*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
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** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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 <u>ONLY</u> 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.

NYS Immunization Requirements

If you have a child entering one of the grades listed in the tables below or who will be of comparable age in September, please contact your child's physician to ensure that your child is in compliance with the current New York State immunization requirements for school attendance.

Immunization requirements for students entering Kindergarten, Grade 1, Grade 2, Grade 3, Grade 4, and Grade 5:

Immunization	Number of Doses Required
Polio	3-4 doses
Hepatitis B	3 doses appropriately spaced
Diphtheria/Tetanus/Pertussis	4-5 doses
Measles/Mumps/Rubella	2 doses
Varicella (Chicken Pox)	2 doses

Immunization requirements for students entering Grade 6:

- Two doses of varicella (chickenpox) vaccine
- Three to four doses of Polio vaccine (IPV)
- Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)

Immunization requirements for students entering Grade 7 and Grade 12:

- Students entering **Grade 7** must have 1 dose of meningococcal vaccine. (They will also be required to get a booster immunization of meningococcal vaccine at age 16.)
- Students entering **Grade 12** must have either:
    - 2 doses of meningococcal vaccine with the second (booster dose) given on or after age 16
    - 1 dose of meningococcal vaccine if your child's first dose was given on or after age 16

Friends Academy

270 Duck Pond Road
Locust Valley, NY 11560

Medication Permission Request Form

Name of Student: _____ Date of Birth: _____
School: _____

To Be Completed By Licensed Health Care Prescriber/MD

Medication Name	Dose	Route	Time at School	Prescriber/MD☑ applicable boxes
				Medication necessary for Field Trips: Yes ☐ No ☐ May Self Admin-Self Carry (for inhalers, Epi Pen or insulin). Yes ☐ No ☐
				Medication necessary for Field Trips: Yes ☐ No ☐ May Self Admin-Self Carry (for inhalers, Epi Pen or insulin). Yes ☐ No ☐
				Medication necessary for Field Trips: Yes ☐ No ☐ May Self Admin-Self Carry (for inhalers, Epi Pen or insulin). Yes ☐ No ☐

Licensed Health Care Prescriber /MD please refer to the following description for insulin, Epi Pen or inhalers

Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Related Diagnosis: _____ ICD code: _____

The following side effects are common: _____

The following side effects should be reported to me: _____

Additional comments: _____

Name and Title of Licensed Health Care Prescriber (Please Print) _____

Prescriber's Signature _____ **Date** _____ **Phone** _____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.
I understand that medication normally given at school during a delayed opening or early dismissal will need to be given at home.

Parent/Guardian Signature _____ ***Date*** _____ ***Phone*** _____

Self-Administer/Self Carry *(for inhalers, Epi Pen or insulin)*

Parent permission and provider consent is required for students to self-administer and self-carry medication (inhalers, Epi Pen or insulin). Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature _____ ***Date*** _____ ***Phone*** _____

Friends Academy

Authorization to Consent to Health Care for Minor

The School will make every reasonable attempt to contact the Parents or another emergency contact in the event of a medical emergency; however, by signing below, Parents authorize the School, its employees, agents and chaperones to: (a) accompany the Student to a medical facility; (b) authorize treatment of the Student by licensed medical personnel; (c) authorize and permit a nurse or first responders (such as EMTs or paramedics) to administer first aid or other treatment to the Student; (d) take any other actions reasonably necessary to treat the Student in the event of a medical emergency; and/or (e) to use and/or disclose pertinent health information to appropriate School representatives charged with the supervision and care of the Student or other health care providers for the treatment of any injury or health condition that may arise at School or during School-related activities. Parents agree that any medical insurance that covers the Student will be the primary insurance coverage for any such treatment.

Parent Signature _____ **Date** _____