



Immaculate Conception School

Dear Parents/Guardians,

As of July 1, 2018 New York State law requires a health examination for **all students entering the school district for the first time and when entering K, 1st, 3rd, 5th, 7th, 9th, and 11th grade.**

The examination must be completed by a New York State licensed physician, physician assistant, or nurse practitioner and on the approved NYSED Student Health Examination form for school.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K, 1st, 3rd, 5th, 7th, 9th, and 11th grade. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the health office with the date.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with the school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number below.

Sincerely,
Amber L Diesfeld RN
Immaculate Conception School Nurse
agreig@icschoolea.org

510 Oakwood Avenue ▪ East Aurora, New York 14052
Phone: (716) 652-5855 ▪ Fax: (716) 805-0192

2023-24 School Year

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "[ACIP-Recommended Child and Adolescent Immunization Schedule](#)." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³		Not applicable	1 dose	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		



Department
of Health



Immaculate Conception School

HEALTH HISTORY

Student Name _____ Home Phone _____

Address _____

Birthplace _____ Date of Birth _____

Father's Name _____ Phone Number _____

Mother's Name _____ Phone Number _____

Personal Physician _____ Phone Number _____

Previous School _____ Phone Number _____

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PLEASE CHECK ANY SIGNIFICANT MEDICAL OR SURGICAL HISTORY AND
PROVIDE ADDITIONAL INFORMATION IN THE SPACE BELOW

Allergies _____
Blood Diseases _____
Asthma _____
Chickenpox _____
Diabetes _____
Ear Conditions _____
Eye Conditions _____
Fractures _____
Heart Disease _____

Lung Disease _____
Neurological Condition _____
Rheumatic Fever _____
Serious Injury _____
Skin Disease _____
Seizures _____
Surgery _____
Whooping Cough _____

PLEASE DESCRIBE ANY PERTINENT INFORMATION ABOUT CONDITIONS
THAT ARE CHECKED ABOVE:

Signature of Parent/Guardian _____ Date _____

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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	Lead Level Required for PreK & K
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	☐	☐		

☐ 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*
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☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision Screening	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening ☐ Pass ☐ Fail					☐
Notes					
Hearing Screening: 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		☐
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐ Yes	☐
FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK					
☐ *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
☐ Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
☐ 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					
☐ Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
☐ Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
☐ Confirmed free of communicable disease during exam			☐ Record Attached ☐ Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: (please print)					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					



Immaculate Conception School

MEDICATIONS AT SCHOOL

WHEN CIRCUMSTANCES MAKE IT NECESSARY FOR THE STUDENT TO TAKE MEDICATION DURING SCHOOL HOURS CERTAIN SCHOOL POLICY **MUST** BE FOLLOWED.

- The prescribing physician must provide a written request stating the name of the medication, dosage, and time of administration. (see attached form)
- The medication must be brought to school by the parent/guardian in the original labeled container. (No medication will be accepted from a student)
- Parent/Guardian must provide written permission to have medication given at school.
- All medication will be kept in the health office and dispensed from there.
- Written requests must be renewed on the first day of school each September.
- All allergy/asthma medications require an allergy/asthma action plan form to be filled out by the doctor and reviewed between the health office and parent/guardian.
- Students will only be permitted to carry medications on school property if the physician has written a medication order acknowledging the student is competent to self-administer. This will also then be reviewed and approved by the health office. This includes over the counter medication as well.

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**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: _____