

CHARACTER • CONFIDENCE • KNOWLEDGE

FROM THE HEALTH OFFICE

Dear Parent or Guardian: Welcome to The Bridges Academy!

Prior to the start of school please inform the School Nurse if your child:

- Has a physical activity restriction
- Has a medical/surgical history or current health concerns
- Has any food or medication allergy/restriction. If your child does have a food allergy requiring an Epi-pen and/or Benadryl to be kept in school, a Food Allergy and Anaphylaxis Emergency Care Plan needs to be filled out by the physician along with a medication authorization form that I mention below.
- Requires medication during school hours (over-the-counter or prescription) on a
 daily basis or on an as needed basis. (Ex: Epi-Pen, Benadryl, Asthma Inhalers,
 Cough Syrup, Motrin, Tylenol), a medication authorization form filled out by the
 parent and physician is required to administer medication during school hours in
 accordance with New York State law. All medication must be brought to school by
 an adult, not the student and must be in the original pharmacy container/packaging
 with your child's name on it, medication cannot be expired.
- Is in need of any immunizations. Please follow up with Physician to make sure required immunizations are up to date. No student may be admitted to school without the New York State Immunization requirements.
- Any medical forms needed can be picked up in the nurse's office, or found on our school website.

If you have any questions or concerns, please contact the School Nurse at (631)358-5035 ext. 30.

My e-mail is Beth.Hughes@bridgesli.org if you need to contact me over the summer.

For your convenience any Physical Exam forms/Medication forms/ Doctor's orders can be faxed directly to School Nurse at (631) 677-3999. I look forward to meeting your child in September!

EMAIL: INFO@THEBRIDGESACADEMY.NET • WWW.THEBRIDGESACADEMY.NET



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REQUIRED HEALTH RECORD FORMS

Dear Parent(s)/Guardian(s):

The physical well-being of your child is an important factor in his or her progress and happiness in school. New York State law requires a health examination for all students entering our school for the first time and when entering <u>Toddler</u>, <u>Nursery</u>, <u>Pre-K</u>, <u>Kindergarten</u>, <u>First</u>, <u>Third</u>, <u>Fifth and Seventh grade</u>.

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 year 2024-2025. Health forms can be found on our Bridges website to print for your convenience.

Please have the approved NYSED Health Examination Form completed by your child's doctor, including a record of all immunizations, based on an examination performed not more than twelve months prior to the start of the school year in which the exam is required, and return this information to the school nurse on or before August 1st.

<u>Please Note:</u>The New York State Department of Health has Immunization Requirements for school Entrance/Attendance. Please confirm with your child sedoctor that their immunizations are up-to-date by August 1st so the school nurse can review the immunization records and contact parents if additional vaccinations are required for attendance.

New York State Education law also requests a dental examination for every new entrant to school and all students in <u>Pre-K, Kindergarten, First, Third, Fifth and Seventh grade.</u> Please send in a "Dental Health Certificate" (can be found on the Bridges website with the health forms.) Have form completed by your child's dentist and returned to the school nurse as it will be filed in your child's Cumulative Health Record.

If your child is scheduled for an upcoming Physical Exam dated after August 1* please return the bottom half of this letter to the health office. Regardless of grade it is always helpful to me if you send in a copy of your child's most current physical to the Health Office. It gives me the most current information so I can better take care of your child when they visit the Health office. Physical Exam forms can be faxed directly to me at (631) 677-3999. For any questions or concerns over the summer, can e-mail me directly at: Beth.Hughes@bridgesli.org

	Sincerely,		
	Beth Hughes, R.N.		
PLEASE RETURN THIS PORTION			
My Child (Name)	Grade:		
HAS AN APPOINTMENT FOR A PHYSICAL ON (Dat	e)		

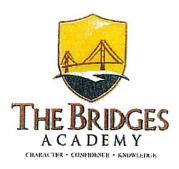
REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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).

		Comn	nittee on Pr	e-School Speci	al education (CF	PSE).			
			STU	DENT INFORM	IATION	A TOTAL CONTRACTOR OF THE CONT		no de site ministra menten e e e e e e e e e e e e e e e e e	
Name:	Affirmed Name (if applicable): DOB:						DOB:		
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lf.	yes to any	diagnoses	below, che	ck all that appl	y and provide a	dditional info	rmation.		
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	☐ Interm		☐ Persiste	***************************************	-	rifike hiller tille fyrifirmið frir fafð á tríkurhóf þer sem sver sællið efti þrá þískilli þjóra kl	nt i name en en epart propriet tot del 1964 tot 1964 t	territoria (Kilota) (M. Martini remai ir para ir myra ir yra ir — a filg unitri maržiolijada) kannama i regunty yra g	
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	Type:				Date of la	ast seizure:	***************************************		
☐ Seizures	☐ Medica	ation/Treat	tment Orde	r Attached	☐ Seizur	e Care Plan A	ttached		
	Туре: 🎑	1 🗆 2							
☐ Diabetes	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached								
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Percentile (Weight Statu	ıs Category):	< 5 th □ 5 ^t	th- 49 th 🏻 50 ^t	th - 84 th 🔲 85 th	-94 th □95 th	- 98 th	□ 99 th and >	
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Height: Weight: BP:			•	Pulse: Respirations:					
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TB-PRN		☐ Test D	Done □ Lead Elevated ≥5 μg/dL						
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System Review With		A 4.44							
Abnormal Findings - List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning or									
'	mph node:		□ Abdomen		☐ Extremities		☐ Speech		
	ardiovascul	ar			1		☐ Social Emotional		
☐ Mental Health ☐ Lungs ☐ Genitourinary					☐ Neurological ☐ Musculoskeletal			culoskeletal	
☐ Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list) ICD-10 Co			ICD-10 Code*			
☐ Additional Information Attached				*Required only	for students v	vith an IF	P receiving Medicald		

5/2023

Name:	immendata musika marana	adeuren 1800 1800 1800 1900 1900 1900 1800 arkan kalenderkan arrak and materiale kalendar saman arra	Affirmed Name (if applicable): DOB:					DOB:	
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		Vision & Hearing Scre	ening	s Required for I	PreK	or K, 1, 3, 5, 7,	& 1 1		
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		student can hear 20dB at a at 6000 & 8000 Hz.	all fre	quencies: 500,	1000), 2000, 3000, 4	000 Hz;		Not Done
Pure Tone Screening		Right Pass Fail	Left	t 🔲 Pass 🔲 Fa	ail	Refer	ral 🗆 Yes		
Notes									
				Negative		Positive	Refer	ral	Not Done
Scoliosis Screening	g: Boys gi	rade 9, Girls grades 5 & 7					□ Ye	21.12.	
<u> </u>	F	OR PARTICIPATION IN I	PHYSI	ICAL EDUCATIO	ON/S	PORTS*/PLAYO	ROUND/V	VORK	MATERIAL STATE SHEET SHE
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Student may p	articipat	e in all activities without	restri	ctions.		andrigate to the free free from the section of the	in . many that is introduced the special production of the special spe	, no oblight a second and a second	erreterreterreterreterreterreterreterr
* '	•	plete the information bel		की केंद्र प्रमुख्य कर कर क					
Hockey, □ Limited Con	, Lacrosse tact Spor t Sports: /	etball, Competitive Cheerle e, Soccer, and Wrestling. ts: Baseball, Fencing, Softb Archery, Badminton, Bowlin	oall, ar	nd Volleyball.				·	
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:									
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Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.									
*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						ger hat eller in the depute has high may any paper many paper may be all helps the state had a new moores.			
☐ Confirmed free of communicable disease during exam ☐ Record Attached ☐ Reported in NY						orted in NYSIIS			
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ang pang rama kele Melikela Meron di Kilolinda mendangkanakan bina pendadibah pinakan di	Please	Return This Form to You	ır Chi	ld's School He	alth (Office When C	ompleted.	de frances de la cardina homes autres conse	учинт кийн уралууларды кара арар Айлай башт үшүйт оон оонун оон оонун кака алаа үшүүчүлөөдү



Dental Health Certificate

Parent(s)/Guardian(s): NYS law permits schools to request a dental examination in the following grades: school entry, Pre-K, K, 1, 3, 5 & 7. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section I and take this 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 II. Return the completed form to the School Nurse as soon as possible.

Section I: To be completed by Parent or Guardian

Child's Name:					
Date of Birth: Grade					
Will this be your child's first visit to the dentist? () Yes () No				
Section II: To be completed by the Dentist					
The student listed above has been examined by a dentist on(date of exam). This student is in fit condition of dental health to permit his/her attendance at school					
Dentist's Name and Address	Dentist's Signature				
(Please print or stamp)					
The Bridges Agademy Logo Shadeson Assess 111 11					



CHARACTER • CONFIDENCE • KNOWLEDGE

School Health Services

AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

	Name of Patient:	
1.	I authorize the healthcare practitioner (na	me and address)(the "Practitioner") and/or the administrative and clinica
staff o	of the Practitioner to disclose my (or my child and address of person/entity to received in	I's or my ward's) protected health information, as specified below, to
2.	I am hereby authorizing the disclosure of	the following protected health information:
(S Ie	pecifically describe the protected health info vel of detail to be released.)	rmation to be disclosed such as date of service, type of service, and
3.	This protected health information is being	used or disclosed for the following purposes:
("At th legal g	ne request of the individual" is acceptable if (quardian of a patient, and they do not want to	the request is made by the patient, the parent of a minor patient, or the state a specific purpose.)
4.	This authorization shall be in force and effe authorization to disclose protected health i	ect until one (1) year after the date below at which time this nformation shall expire.
5.	notification to the Practitioner at the address	this authorization, in writing, at any time by sending such written above. I understand that a revocation is not effective to the extent orization or if my authorization was obtained as a condition of the er has a legal right to contest a claim.
6.	In understand that information disclosed p may no longer be protected by HIPAA or a	ursuant to this authorization may be disclosed by the recipient and ny other federal or state law.
7.	The Practitioner will not condition my treat health care services are provided to me sole disclosure to a third party.	ment on whether I provide an authorization for disclosure except if ly for the purpose of creating protected health information for
Signatu Or Pers	re of Patient, or Parent of Minor Patient, onal Representative of Patient	Date
Or Pers	ame of Patient, Parent of Minor Patient onal Representative of Patient (If a personal entative, also state relationship to patient.)	(Provide a copy of this form to the patient.)