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!

THE BRIDGES ACADEMY

CHARACTER • CONFIDENCE • KNOWLEDGE

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 Toddler, Nursery, Pre-K, Kindergarten, First, Third, Fifth and Seventh 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 year 2023-2024. 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.**

Please Note: The New York State Department of Health has Immunization Requirements for school Entrance/Attendance. Please confirm with your child's doctor 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 Pre-K, Kindergarten, First, Third, Fifth and Seventh grade. 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 1st 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 (Date) _____

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).

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	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/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*
☐ 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	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
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	☐

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 Dominic 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*:** (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**
☐ 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.

THE BRIDGES ACADEMY
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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
(Please print or stamp)

Dentist's Signature

School Health Services

AUTHORIZATION FORM (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient: _____

1. I authorize the healthcare practitioner (name and address) _____ _____ (the "Practitioner") and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below, to (name and address of person/entity to received information):

2. I am hereby authorizing the disclosure of the following protected health information:

   (Specifically describe the protected health information to be disclosed such as date of service, type of service, and level of detail to be released.)

3. This protected health information is being used or disclosed for the following purposes:

("At the request of the individual" is acceptable if the request is made by the patient, the parent of a minor patient, or the legal guardian of a patient, and they do not want to state a specific purpose.)

4. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. In understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

7. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient, or Parent of Minor Patient, Or Personal Representative of Patient — Date

_____

Print Name of Patient, Parent of Minor Patient Or Personal Representative of Patient (If a personal Representative, also state relationship to patient.)

(Provide a copy of this form to the patient.)

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

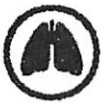
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

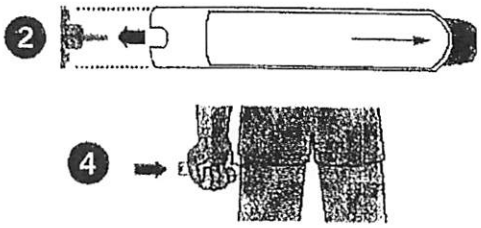
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

THE BRIDGES ACADEMY

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

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.*

Parent Signature _____ Date_____

B. **To be completed by the Private Healthcare Provider**:

I request that my patient, as listed below, receive the following medication:

Student's Name_____ DOB_____

Diagnosis_____

Medication_____

Dosage_____Route_____Frequency_____

Time to be taken during school hours_____

Possible side effects or adverse reactions (if any):

_____

Health Care Provider's
signature:_____Date_____

Physician Information: (Please Stamp)

This medication order is valid for SCHOOL YEAR 2024-2025

*Medication must be in the original pharmacy labeled container with specific orders and name of student and medication.
**Medication and refills must be brought to school by a parent, guardian or responsible adult.