CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___/___/___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District Number** ___ | **Phone Numbers** Home ______ Cell ______ Work ______

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** | **First Name** | **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)*** ☐ None ☐ Yes *(list below)*

______

PHYSICAL EXAM **Date of Exam:** ___/___/___

Height	______ cm	(____ %ile)
Weight	______ kg	(____ %ile)
BMI	______ kg/m²	(____ %ile)
Head Circumference *(age ≤2 yrs)*	______ cm	(____ %ile)
Blood Pressure *(age ≥3 yrs)*	______ / ______	

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	______ µg/dL
	___/___/___	______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	______ g/dL ______ %

Hearing	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
OAE	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*

Vision	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ____/____ Left ____/____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental		
Visible Tooth Decay	☐ Yes	☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes	☐ No
Dental Visit within the past 12 months	☐ Yes	☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐ Physician Confirmed History of Varicella Infection ☐ Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ______	___/___/___		

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)*

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY PRACTITIONER I.D. ☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: | I.D. NUMBER ☐☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2020-2021

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name First Name Middle Initial

Date of Birth ___/___/______ (MM DD YYYY)

☐ Male ☐ Female

OSIS # ___________ DOE District ___ Grade/Class ______

School ATSDBN/Name Address, and Borough:

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
☐ Asthma
☐ Other:______________

Control *(see NAEPP Guidelines)*
☐ Well Controlled
☐ Not Controlled / Poorly Controlled
☐ Unknown

Severity *(see NAEPP Guidelines)*
☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

	Y	N	U	
History of near-death asthma requiring mechanical ventilation	☐	☐	☐	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐	☐	☐	
History of asthma-related PICU admissions (ever)	☐	☐	☐	
Received oral steroids within past 12 months	☐	☐	☐	____ times last: ___/___/___
History of asthma-related ER visits within past 12 months	☐	☐	☐	____ times
History of asthma-related hospitalizations within past 12 months	☐	☐	☐	____ times
History of food allergy or eczema, specify: ____________	☐	☐	☐	

Student Skill Level *(Select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers under adult supervision

☐ Independent Student: student is self-carry/self-administer
I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

______ Practitioner Initials

Quick Relief In-School Medication

☐ **Albuterol** [*Only generic Albuterol MDI is provided by school for shared usage*] *(plus individual spacer)*: ☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standard Order: Give 2 puffs q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath.
Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give 6 puffs; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** 2 puffs @ noon for 5 school days.
Special Instructions:

☐ **Other:** Name: ______________ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Give ___ puffs/___AMP q ___ hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give ___ puffs/ ___AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** ___ puffs/___ AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** ___ puffs/___ AMP @ noon for 5 school days
Special Instructions:

Controller Medications for In-School Administration

(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone** [Only *Flovent® 110 mcg MDI is provided by school for shared usage*]
☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standing Daily Dose:___ puffs ONCE a day at ___AM
Special Instructions:

☐ **Other ICS Standing Daily Dose:**
Name: ______________ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Home Medications *(Include over the counter)*

☐ Reliever ______________ ☐ Controller ______________ ☐ Other ______________

Health Care Practitioner (Please print name and circle one: MD, DO, NP, PA)
Last First

Signature

Date ___/___/______

Address

Tel. (___)___-____

Fax (___)___-____

NPI # __________

Email Address

NYS License # **(Required)**

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. | REV 4/20

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year 2020-2021

Please return to school nurse. Forms submitted after June 1, 2020 may delay processing for new school year.

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment, including non-albuterol inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma medicine is not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the doctor's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
   - When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner may fill out a new MAF so my child can continue to receive health services through OSH. My health care practitioner or the OSH health care practitioner will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
   - This form represents my consent and request for the asthma services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved self-administered medications with your child on a school trip day and/or after-school program in order for he/she to have it available. Stock medications are for use by OSH staff in school only.

Student Last Name First MI | Date of Birth ___/___/______

School ATSDBN/Name | **District** | **Borough**

Parent/Guardian Print Name: ____________________ SIGN HERE **Signature:** ____________________

Date Signed ___/___/______ Parent/Guardian's Address:

Cell Phone (___)___-____ Other Phone (___)___-____ **Email:** ____________________

Other Emergency Contact Name/Relationship: ____________________ Emergency Contact Phone: (___)___-____

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: ____________ ☐ 504 ☐ IEP ☐ Other

Received By Name: ____________ Date ___/___/___ | Reviewed By Name: ____________ Date ___/___/___

Services Provided By ☐ Nurse/NP ☐ School-Based Health Center ☐ OSH Public Health Advisor *(For supervised students only)* ☐ OSH Asthma Case Manager *(For supervised students only)*

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Modified ☐ Not Modified

Signature and Title (RN OR MD/DO/NP): ____________________

Confidential information should not be sent by email

FOR PRINT USE ONLY

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

Student Last Name	First Name	Middle	**Date of birth** ___/___/______ MM DD YYYY	☐ Male ☐ Female
OSIS Number __ __ __ __ __ __ __ __ __	**Weight** ________kg			
School (include ATSDBN/name, number, address and borough)		**DOE District**	**Grade**	**Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	**Specify Allergy**	**Specify Allergy**
☐ Allergy to	☐ Allergy to	☐ Allergy to

			Does this student have the ability to:		
History of asthma?	☐ Yes ***(If yes, student has an increased risk for a severe reaction)***	☐ No	Self-Manage *(See 'Student Skill Level' below)*	☐ Yes	☐ No
History of anaphylaxis?	☐ Yes Date ___/___/______	☐ No	Recognize signs of allergic reactions	☐ Yes	☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize/avoid allergens independently	☐ Yes	☐ No
Treatment	Date ___/___/______				

Select In School Medications

1. SEVERE REACTION

A. **Immediately administer epinephrine ordered below, then call 911.**

☐ 0.15 mg
☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for **any** of the following symptoms *(retractable devices preferred)* :

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:____________________

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):____________________
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

B. If no improvement, or if symptoms recur, repeat in ______ minutes for maximum of _____ times (not to exceed a total of 3 doses)

C. Give antihistamine after epinephrine administration (*order antihistamine below*)

Student Skill Level *(select the most appropriate option)*	☐ Independent Student: student is self-carry/self-administer	
☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer ☐ Supervised Student: student self-administers, under adult supervision	*I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.*	**Practitioner's Initials**

2. MILD REACTION

A. Give antihistamine: Name:____________________Preparation/Concentration:____________ Dose:__________ Route: ________
Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for **any** of the following symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other: ____________

B. If symptoms of severe allergy/anaphylaxis develop, or if more than one symptom from each system is present, use epinephrine and call 911.

Student Skill Level *(select the most appropriate option)*	☐ Independent Student: student is self-carry/self-administer	
☐ Nurse Dependent Student: nurse must administer ☐ Supervised Student: student self-administers, under adult supervision	*I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.*	**Practitioner's Initials**

3. OTHER MEDICATION

- Give Name:____________________Preparation/Concentration:____________ Dose: ____________
  Route:__________ Frequency: Q________ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:____________________
If no improvement, indicate instructions:____________________
Conditions under which medication should not be given: ____________________

Student Skill Level *(select the most appropriate option)*	☐ Independent Student: student is self-carry/self-administer	
☐ Nurse-Dependent Student: nurse must administer ☐ Supervised Student: student self-administers, under adult supervision	*I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.*	**Practitioner's Initials**

Home Medications *(include over-the counter)*

____

Health Care Practitioner Name LAST FIRST **(Please print and circle one:** MD, DO, NP, PA)	Signature	Date ___/___/______
Address	Tel. (____)_____-______	Fax. (____)_____-______
NYS License # **(Required)** NPI # ___ ___ ___ ___ ___ ___ ___		

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2020–2021

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the allergy services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child epinephrine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: If you decide to use stock, you must send your child's epinephrine, asthma inhaler and other approved self-administered medications on a school trip day and/or after school programs in order that he/she has it available. Stock medications are only for use by OSH staff in school only.

Student Last Name First Name MI	Date of birth ____/____/________	School
School ATSDBN/Name	Borough	District
Parent/Guardian's Name (Print) SIGN HERE	**Parent/Guardian's Signature**	**Date Signed** ___/___/______
Parent/Guardian's Email	**Parent/Guardian's Address**	

Telephone Numbers: Daytime (_____)_____-______ **Home** (_____)_____-______ **Cell Phone** (_____)_____-______

Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number** (______)_____-______

For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name Date ___/___/_____ **Reviewed by:** Name Date ___/___/_____

☐ 504 ☐ IEP ☐ Other **Referred to School 504 Coordinator:** ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor *(For supervised students only)* ☐ School Based Health Center

Signature and Title (RN OR SMD): **Date School Notified & Form Sent to DOE Liaison** __ / __ / ____

Revisions as per OSH contact with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential Information should not be sent by email

FOR PRINT USE ONLY

Is Your Child Ready for Child Care or School?

2020-2021 School Year

[illegible] in New York City.

All students ages 2 months to 18 years in New York City must get the following vaccinations to go to child care or school. Review your child's vaccine needs based on their grade level this school year.

VACCINATIONS	PRE-K	Kindergarten– Grade 5	Grades 6 – 12
Diphtheria, tetanus and pertussis (DTaP)	**4 doses**	**5 doses** **or 4 doses** ONLY if the fourth dose was received at age 4 years or older **or 3 doses** ONLY if the child is 7 years or older and the series was started at age 1 year or older	**3 doses**
Tetanus, diphtheria and pertussis booster (Tdap)			**1 dose (at or after age 11 years)**
Polio (IPV or OPV)	**3 doses**	**4 doses** **or 3 doses** if the third dose was received at age 4 years or older	
Measles, mumps and rubella (MMR)	**1 dose**	**2 doses**	
Hepatitis B	**3 doses**	**3 doses**	**3 doses** **or 2 doses** of adult Hepatitis B vaccine (Recombivax HB) if the doses were received at least 4 months apart between the ages of 11 and 15 years
Varicella (chickenpox)	**1 dose**	**2 doses**	
Meningococcal conjugate (MenACWY)			**Grade 6:** Not applicable **Grades 7 – 11: 1 dose** **Grade 12: 2 doses** or 1 dose ONLY if the first dose was received at age 16 years or older
Haemophilus influenzae type B conjugate (Hib)	**1 to 4 doses** Depends on child's age and doses previously received		
Pneumococcal conjugate (PCV)	**1 to 4 doses** Depends on child's age and doses previously received		
Influenza	**1 dose**		

The number of vaccine doses your child needs may vary based on age and previous vaccine doses received. Your child may need additional vaccines or vaccine doses if they have certain health conditions. Talk to your health care provider if you have questions. For more information, call **311** or visit **nyc.gov/health** and search for **student vaccines.**

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