Edgemont School
District Greenville
School
Seely Place School
Scarsdale, NY 10583

Jennifer Allen, Principal

Eve Feuerstein, Principal

Dear Parent(s)/Guardian(s),

Welcome to Edgemont! We are thrilled that you are joining our community and we look forward to getting to know your children and you over the years to come!

Attached you will find a packet of required medical forms to fill out as well as information about our Health Office practices and requirements. Please read everything thoroughly and contact our school nurses if you have any questions.

We would like to stress a particularly important piece of information which is that students must be completely up-to-date with all required immunizations prior to the first day of school or they will not be permitted to attend class. This packet contains a chart with all required immunizations; please consult with your pediatrician to confirm that all have been administered. We are all eager to meet all of our new students on the first day of school so we strongly encourage you to ensure that all of your child's immunizations are current so that he/she can get off to a great start!

In addition, all students must have a current medical exam completed within the first two weeks of school. We encourage you to have this done prior to the start of school in order to ensure that there is no disruption to your child's school attendance.

We hope that your transition to Edgemont is a smooth one and wish you the best.

Sincerely,

Jennifer Allen
Greenville School Principal

Eve Feuerstein
Seely Place School Principal

Edgemont School District
Greenville and Seely Place Elementary Schools
New Student Welcome Packet
Health Office

Hello families,

Welcome to Edgemont School District. We are very excited for you to join our community! Please read the following information to ensure that your child's transition will be a smooth one.

If you are transferring to Edgemont from **within** New York State, we ask that you submit a copy of your child's current Health Appraisal (physical exam) and immunization record. This must be from within the last year. All immunizations must be up to date before the start of school. New York State requires all students to be immunized before they attend school. The only exceptions are students with medical or religious exemptions. Please note, if you are unable to provide this information, then your child will be excluded from school.

All out of state incoming students will need to have a completed Health Appraisal (physical exam) administered by a New York State physician within 2 weeks from the start of school. If you are out of the country, you will be granted a 30 day grace period from the start of school to complete this process.

A dental examination is required during the school year.

Forms are located on the "Greenville" and "Seely" school website. Look under "departments" and then under "health office". You will need to print out "incoming student packet". You will only need to fill out the "Emergency Health Forms" if your child has a food or insect allergy.

Our school physician is Dr. Eric Small who is located at 220 North Central Avenue, Hartsdale 914-666-7900. Please call our office for a list of other physicians in the area.

If you have any medical concerns or issues, please speak with the Health Office before your child starts school.

We have attached a copy of our Health Office policy for your review.

Greenville Health Office phone is 914-472-7764. Greenville fax number 914-472-3161. Seely Place Health Office phone is 914-472-8043. Our office hours are from 8:15am -3:45pm Monday through Friday. We can also be reached by email if there are any questions and/or concerns.

Thank you very much.

Greenville School Nurses

Seely Place School Nurse

Edgemont Union Free School District at Greenburgh
Scarsdale, New York 10583

Elementary School Health Office Policy

Greenville Health Office 914-472-7764
Diane Rakoff, RN drakoff@edgemont.org

Seely Place School 914-472-8043
Gail Krone, RN gkrone@edgemont.org

In order to best care for your children, we ask that you follow the reminders we have listed below:

1. Please call or email the Health Office by 8:45 am if your child is going to be absent or late. If you know of any absence in advance, please notify the teacher **and** the Health Office.

2. Please have your child stay at home if he/she is not feeling well. If he/she goes to school, his/her condition may worsen and his/her illness may spread to others. A child may return to school after all symptoms are gone and he/she is diarrhea/vomit/fever free for 24 hours. Please report to our office any confirmed diagnosis of any contagious illness such as strep throat, conjunctivitis, fifths disease, flu, etc.. Also please report any case of head lice.

3. Please keep all medical information up to date.

4. Physical exams (health appraisals) are required every year. All students must have a current health appraisal on file from a New York State physician. All immunizations that are required by New York State must be given prior to entrance to school.

5. New York State has regulations for the administration of medication in school. The following steps should be taken if your child is in need of any medication, including over the counter medication during the school day.
    a. We must have on file a written request signed by you and your physician.
    b. All medication must be delivered to the Health Office by the parent.
    c. The medication must be in the original container, as it is received from the pharmacist. Over the counter medication must be in the original container and be labeled with the name of the child and the description of the dosage.
    d. The medication must be kept in the Health Office.

6. If a student needs to be excused from PE and/or recess, they must submit a note from their doctor explaining why and for how long.

7. Vision and hearing tests are done throughout the school year. If you should notice a problem, please call us. Teachers will also bring any concerns they have to our attention.

8. Please remember to notify us when there is a change in your emergency or work telephone numbers.

9. Keep in close contact with the school if there are any significant changes in your home.

Thank you for your cooperation.

Diane Rakoff, RN
Greenville School Nurse

Gail Krone, RN
Seely Place Nurse

EDGEMONT UNION FREE SCHOOL DISTRICT

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires an annual physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers

Name: DOB: Gender: ☐ M ☐ F

School: Grade: ☐NA Exam Date:

HEALTH HISTORY

Specify Current Diseases				
☐Asthma (☐Intermittent or ☐Persistent)	Sickle Cell Screen:	☐Positive	☐Negative	☐Not Done Date:
Quick relief inhaler: ☐Yes ☐No	PPD:	☐Positive	☐Negative	☐Not Done Date:
Asthma Action Plan: ☐Yes ☐No	Elevated Lead:	☐Yes	☐No	☐Not Done Date:
☐Type 1 Diabetes ☐Type 2 Diabetes	Dental Referral:	☐Yes	☐No	☐Not Done Date:
☐Hyperlipidemia ☐Hypertension				
☐Other:	☐ Allergies - See page 2 for details.			

Significant Medical/Surgical Information:

PHYSICAL EXAMINATION

Height: Weight: BP: Pulse: Respirations:

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer: _____

Body Mass Index:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th- 94th

☐ 5th- 49th ☐ 95th- 98th

☐ 50th-84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐Yes ☐No
Distance acuity with lenses			
Vision - near vision			
Vision - color perception	☐ Pass	☐ Fail	

Hearing	Right	Left	*Referral*
☐ 20 db sweep screen both ears or			☐Yes ☐No

Circle developmental stage (ONLY for selection classification for 7th & 8th graders): Tanner: ☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ See attached

Specify any abnormalities:

RECOMMENDATIONS OR RESTRICTIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ Free from contagions and physically qualified for all activities (phys ed, athletics, playground, work, school)

☐ Expected Body Contact (full or limited): football, wrestling, basketball, ice/field/floor hockey, baseball, softball,

☐ Strenuous: cross-country, gymnastics, track & field, swim, diving, crew, ski, cheering, tennis, badminton, fencing,

☐ Non-contact/Non-strenuous: bowling, golfing, table tennis, archery, riflery, shuffleboard, walking

☐ Protective Equipment: ☐Athletic Cup ☐Sport/safety goggles ☐Other:

☐ Medical/prosthetic device:

☐ Recommendations/restrictions:

Name: DOB:

MEDICATIONS

To be completed by Health Care Provider

Diagnosis	ICD Code	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

***Self Directed:** I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately, and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently

****Self Admin/Self-Carry:** I have determined this student is consistent and responsible in taking their own medication (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.

To be completed by Parent/Guardian if medication is prescribed

☐ 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/package with my child's name on it.

Parent/Guardian Signature: Date: Phone: ( )

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication. 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: ( )

ALLERGIES

☐ **None** ☐ **Non Life-Threatening** ☐ **Life-Threatening**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Specify allergen(s):

Specify previous symptoms: ☐History of anaphylaxis; last occurrence:

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

IMMUNIZATIONS

☐ Immunization record attached
☐ Immunizations reported on NYSIIS
☐ No immunizations received today

☐ Immunizations received today:

☐ Will return on: to receive:

Provider / Parental Authorization

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: Date:

Provider Name: (please print) Phone #:

Provider Address: Fax #:

Parent/Guardian Signature: _____ Date:

Return to:

School Nurse: School:

Phone #: ( ) Fax: ( ) Date:

HEALTH OFFICE

MEDICATION AUTHORIZATION FORM

Individualized Orders for: _____ D.O.B. _____

Allergies: _____

1. **Standard Over-the-Counter/PRN Medications:** The following medications are the *only* ones available in the Health Office. For any other medications, see below. These medications will be administered at the discretion of the RN, ***only if signed approval is indicated by BOTH the student's physician AND parent.***

Drug Name	Route	Dosage	Schedule & Indications	Comments
Tylenol tablets (acetaminophen)	po		Q___ Hr. for:	
Advil tablets (ibuprofen)	po		Q___ Hr. for:	
Throat Lozenges	po		Q___ Hr. for:	
Benadryl capsules (diphenhydramine hydrochloride)	po		Q___ Hr. for:	

2. **PRESCRIPTION and any other Over-the-Counter Medications:** Please complete with patient's current regimen for both scheduled and PRN medications.

All medications must be provided directly to the nurse by a responsible adult in the original container with your student's name on it.

Drug Name	Route	Dosage	Schedule & Indications	Comments

Physician Signature: _____ Date: _____

License #: _____ Phone #: _____

I authorize the school RN to dispense the medication prescribed by the above physician.

Parent signature: Date:

2016-17 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 8, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: Intervals between doses of polio vaccine need to be reviewed only for grades prekindergarten, kindergarten, 1, 2, 6, 7 and 8.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 9 through 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should 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	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1 and 2	Grades 3, 4 and 5	Grades 6, 7 and 8	Grades 9, 10, 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years of age or older or **3 doses** if aged 7 years or older and the series was started at 1 year of age or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine 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 of age or older	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years of age or older	**3 doses**
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 of age			
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**		**By Grade 7: 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years of age 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**			

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at ages 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years of age or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children ages 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years of age or older will meet the 6th grade Tdap requirement.
   e. For children 7 years of age or older who received the first dose on or after their first birthday, the immunization requirement is 3 doses. If the first dose was received before their first birthday, then 4 doses are required.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years of age or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years of age or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years of age.

4. Poliovirus vaccine (IPV/OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at ages 2 months, 4 months and at 6 through 18 months, and 4 years of age or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at age 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Students in grades kindergarten through 12 must have received 2 doses of measles-containing vaccine, 2 doses of mumps-containing vaccine and at least 1 dose of rubella-containing vaccine.
   c. One dose of MMR is required for prekindergarten.

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than 24 weeks of age.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children aged less than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate vaccine (MenACWY). (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menevo) is required for students entering grade 7.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at age 16 years or older, the second (booster) dose is not required.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months of age.
   b. If 2 doses of vaccine were received before 12 months of age, only 3 doses are required with dose 3 at 12 through 15 months of age and at least 8 weeks after dose 2.
   c. If dose 1 was received at ages 12 through 14 months of age, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months of age or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years of age or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months of age.
   b. Unvaccinated children 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at age 12 through 15 months.
   c. Unvaccinated children 12 through 23 months of age are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months of age or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at www.health.ny.gov/prevention/immunization/schools

For further information contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

EDGEMONT UFSD, SCARSDALE, NY 10583

DENTAL FORM

Name of student _____

Address _____

Grade _____

Please have this form completed by your family dentist at the time of your child's dental examination.

___ Patient has been examined and requires no treatment at this time.

___ Patient is under dental treatment at this time.

___ Patient has completed all dental treatment.

Additional Remarks

Date _____

Dentist's Signature _____