Long Lake
CENTRAL SCHOOL DISTRICT

School Entrance Requirements

Dear Families,

The start of the new school year is always a fun and exciting time. It seems like there is so much to do to get ready for the first day of school. I have listed below the documents that must be completed, signed, and returned prior to or on the first day of classes:

- **Birth Certificate** (if not previously provided)
- **Copy of a Lead Screening**
  - *Only* required for students entering pre-kindergarten.
- **Copy of Official Immunization Record**
  - The type of vaccine and the number of doses required for each grade level is outlined on the *New York State Immunization Requirements for School Entrance/Attendance* informational sheet.
  - Students without evidence of having received all required vaccinations within 14 days from the first day of school will be prohibited from attending.
- **Completed *Required NYS School Health Examination Form*** (form enclosed)
  - Healthcare Providers (HCP)/physicians must use this form.
  - Physicals must be completed within 12 months prior to the start of school.
- **Completed *Dental Health Certificate* Form** (form enclosed)
  - This form may be used by your dentist to show proof of dental examination.
  - Certificate must be completed within 12 months prior to the start of school.
- **Completed *Permission for Sharing Confidential Medical Information* Form** (form enclosed)
- **Completed *Administration of Over-the-Counter Medication* Form** (form enclosed)
  - After parent/guardian completes and signs the form, it must be signed by your HCP/physician in order for your child to receive over-the-counter medication if needed.
- **Completed *Permission for Prescribed Medication* Form** (form enclosed)
  - This form is to be used *only* for students requiring administration of prescription medications during the school day.
  - The form requires completion and signature from parent/guardian and HCP/physician.
- **Completed *Informed Consent for COVID-19 Testing* Form** (form enclosed)
  - COVID-19 testing will be performed when a student is symptomatic, has been exposed, or when required by public health.
  - Parents/guardians will be notified of positive test results.
- **Completed *Sunscreen / Bug Spray Permission Slip* Form** (form enclosed)

Attendance is paramount for your child to have a successful learning experience. Parents/guardians are to notify the school at the beginning of the school day with the reason for a child's absence. A written excuse explaining the cause of absence is required on the day the child returns to school otherwise the absence will be considered unexcused. Please make every effort to schedule appointments and family vacations at times when school is not in session.

Thank you in advance for your cooperation. If you have any questions, please feel free to contact me at (518) 624-2221 ext. 308 or mbillings@longlakecsd.org.

Sincerely,

Michelle Billings, RN
School Nurse, School Attendance Officer

Long Lake Central School District

Health and Dental Examination Requirements

Dear Parents/Guardians,

New York State law requires a **health examination** for all students **entering the school district for the first time and when entering Pre-K or 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 within 12 months prior to the commencement of the school year.

A **dental certificate** which states your child has been seen by a dentist or dental hygienist **is also asked for at the same time.** The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- 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 Pre-K or K, 1st ,3rd , 5th, 7th , 9th & 11th grades. 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.
- For your convenience, a physical exam form and dental certificate for your health care providers is enclosed.
- 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 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,

School Nurse: Michelle Billings, RN		School: Long Lake CSD
Phone #: (518)624-2221 ext. 308	Fax: (518)624-3896	Email: mbillings@longlakecsd.org

2023-24 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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**		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or 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 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years 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 and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. Children 7 years and older 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 or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.
   c. 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 old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years 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 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

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. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

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 age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   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 younger 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 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

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.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

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.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

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

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	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 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.

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female ☐ X

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address

(please print or stamp) **Dentist's/Dental Hygienist's Signature**

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Long Lake
CENTRAL SCHOOL DISTRICT

Permission for Sharing Confidential Medical Information Among Professionals About A Minor Student

Please review the below and initial as appropriate.

I / We, the undersigned, as parent(s) / guardian(s) of _____, a student in Long Lake CSD for the _____school year:

_____/_____ **Do not** authorize the transfer of personal confidential health information about the student to be shared at all with any school personnel.

_____/_____ **Do** authorize the transfer of personal confidential health information about the student to be shared among the following personnel as initialed if it is deemed important and helpful to the health of the student and/or the public health of the school. Any category of personnel not checked and initialed shall not be allowed access to such information.

_____/_____ All of the following
_____/_____ Student's private physician
_____/_____ School physician (if different from the private physician)
_____/_____ School nurse/PA
_____/_____ Superintendent
_____/_____ Other administrative personnel
_____/_____ Faculty
_____/_____ Faculty aides and assistants
_____/_____ Physical education/coaching personnel
_____/_____ Bus Drivers
_____/_____ Food service personnel
_____/_____ Janitorial personnel
_____/_____ Emergency Contacts
_____/_____ Other: _____

In addition to the above, I specifically direct the following person(s) or category(ies) of personnel to NOT be allowed access to such intonation.

_____

_____

_____
Parent/Guardian 1's Name (*please print*)

_____
Parent/Guardian 2's Name (*please print*)

_____
Signature

_____
Signature

_____
Date

_____
Date

Long Lake
CENTRAL SCHOOL DISTRICT

Administration of Over-the-Counter Medication
Standing Order

Not uncommonly there have been instances when the school has not been able to reach a parent/legal guardian to obtain permission to administer minor pain relievers/fever reducers and other non-prescription topical or oral medication to a student in a timely fashion. In order to expedite treatment of Long Lake Central School students when they are experiencing minor discomfort, the following permission/order will allow the School Nurse or Nurse substitute to administer over-the-counter medication (as listed below) without obtaining parental/legal guardian permission at that specific time. Of course, follow-up contact will be attempted by phone or by written note sent home with the student. Please initial next to each medication with which you are comfortable and sign the form. You will then need to have your child's Health Care Provider sign off on the form also.

****

The School Nurse or Nurse Substitute has my permission to administer the following medication(s) to my child_____as deemed necessary or advisable after appropriate assessment for the _____school year.

_____ Acetaminophen (Tylenol)
_____ Antacid (Tums)
_____ Calamine Lotion
_____ Diphenhydramine (Benadryl)
_____ Hydrocortisone Cream 1%
_____ Ibuprofen (Advil, Motrin)
_____ Orajel
_____ Saline Eye Wash
_____ Topical Antibiotic Ointment (Neosporin)

Parent / Guardian Name (please print): _____
Parent / Guardian Signature: _____ **Date:** _____

Health Care Provider (please print): _____
Health Care Provider Signature: _____ **Date:** _____

LONG LAKE CENTRAL SCHOOL DISTRICT
PERMISSION FOR PRESCRIBED MEDICATION

7513F

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ School Year: _____ Date form received: _____
I/we acknowledge receipt of this Physician's Statement and Parent Authorization: _____

Student Name: _____ Student age: _____ Date of Birth _____
Grade: _____ Homeroom/Classroom: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: _____
Reason for medication: _____
Form of medication treatment:
[ ] Tablet/capsule [ ] Liquid [ ] Inhaler [ ] Injection [ ] Nebulizer [ ] Other _____
Instructions (Schedule and dose to be given at school): _____
_____

Start: [ ] Date form received [ ] Other, as specified: _____
Stop: [ ] End of school year [ ] Other date/duration: _____
[ ] For episodic/emergency events only

Restrictions and/or important side effects: [ ] No restrictions
[ ] Yes. Please describe: _____
_____

Special storage requirements: [ ] None [ ] Refrigerate
Other: _____
Physician's Signature _____
Date _____ Phone _____ Address _____

For Self-Administration ONLY **For Self-Administration ONLY** **For Self-Administration ONLY**

Pursuant to KRS 158.832 to KRS 158.836 _____ *school permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.*

This student has been instructed on self-administration of this medication: **to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY**
[ ] No [ ] Supervision Required [ ] Supervision not required
This student may carry this medication: [ ] No [ ] Yes
Please indicate if you have provided additional information:
[ ] On the back side of this form [ ] As an attachment
Signature: _____ Date _____
Physician or Authorized Provider

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to standard school policy. I release the _____ School Board and its employees from any claims or liability connected with its reliance on this permission. (Parents/guardians to bring the medication in its original container.)
Date: _____ **Signature:** _____ **Relationship:** _____
Home phone: _____ **Work phone:** _____ **Emergency phone:** _____

HAMILTON COUNTY PUBLIC HEALTH NURSING SERVICE

Erica Mahoney, DPT
Director of Public Health
erica.mahoney.hcphns@frontier.com

Public Health Programs: (518)648-6497
Fax: (518) 648-6143
www.hamiltoncounty.com

PO Box 250, 139 White Birch Lane
Indian Lake, NY 12842

Carriann Grexa-Allen, DNP, RN, CIC
Director of Patient Services
Carriann.grexaallen.hcphns@frontier.com

Certified Home Health Agency: (518) 648-6141
After Hours: (518) 548-3113 Sheriff's Office
Like us on Facebook: www.facebook/HCPHNS

SARS-CoV-2 Test
Provider: David G. Welch, MD NPI#:1801977376

Patient Information:

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age: _____ Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

School Information:

☐ Attend School ☐ Work at School ☐ Volunteers at School

Level: Check all that apply:

☐ Elementary ☐ Middle School ☐ Secondary

Informed Consent for COVID-19 Testing

a) I authorize this COVID-19 testing unit to conduct collecting and testing for COVID-19 through a nasal swab, as ordered by an authorized medical provider or public health official.
b) I authorize my test results to be disclosed to the county, state, or to any other government entity as may be required by law.
c) I acknowledge that a positive test result in an indication that I must continue to self-isolate in an effort to avoid infecting others.
d) I understand that I am not creating a patient relationship with Hamilton County Public Health by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns or fi my condition worsens.
e) I understand that, as with any medial test, there is a potential for false positive or false negative test results.
f) I, undersigned, have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

Parent/Guardian Name: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____

Date: _____

The Hamilton County Public Health Nursing Service is committed to providing preventative and restorative health services to the residents and guests of Hamilton County.

Long Lake
CENTRAL SCHOOL DISTRICT

Sunscreen / Bug Spray Permission Slip

I hereby give permission for my child, _____, to wear sunscreen and/or bug spray as deemed appropriate. I understand that I will provide sunscreen and/or bug spray with my child's name on the bottle. I may apply sunscreen and/or bug spray on my child before they come to school and will inform the teacher if this is the case. The teachers have my permission to reapply sunscreen and/or bug spray as needed throughout the day.

_____ Please allow my child to apply his/her own sunscreen and/or bug spray as needed.

_____ Please apply sunscreen and/or bug spray on my child as needed.

_____ _____

Parent / Guardian Signature Date

_____

Parent / Guardian Name (Please Print)