Dear Parent/Guardian,

No child is officially accepted to Long Island Middle & High School until acceptable proof of immunization is on file. This record must have a doctor's stamp and signature.

Acceptable proof of immunity means:

1. Exact date of immunization signed by a physician, or
2. Serologic proof of immunity

Full immunization means:

1. MCV4 (Menactra or Menveo) 1 dose is required before entering 7th, 8th, 9th and 10th grade. Two doses are required in 12th grade unless the first dose was given on or after the age of 16.
2. DTaP – 3 doses are required for all students.
3. Tdap – 1 dose is required for all students.
4. Polio vaccine - 4 doses of IPV/OPV are required for all students entering 6th through 12th grade or 3 doses if the 3rd dose was received at 4 years of age or older.
5. MMR 2 doses are required for all students.
6. Hepatitis B vaccine – doctor verification of pediatric 3 doses or adult 2 doses (Recombivax) are required for all Students.
7. Varicella – 2 doses are required for all students entering grades 6th through 12th.

All **new** students and students entering 7th, 9th and 11th grades must present a copy of a current physical exam to be kept on file in the health office. Any student wishing to participate in athletics are also required to submit a copy of a physical exam that is dated no more than one year prior to the beginning of tryouts for a particular sport. Please note that the NYS Physical Form, located in the myLuHi Document Library and in this packet, is the only physical form that will be accepted. All forms contained in this letter must be completed and submitted to LuHi's Health Office.

All medication (prescription or over-the-counter) that will be taken during the school day must be brought to the health office. Medication must be in the original container accompanied by a medication administration form (found in the document library of my LuHi) that is filled out by both a parent/guardian and physician. The student may then report to the nurse who will administer medication as indicated by a physician's prescription. Parents are notified if a child has an accident or becomes ill during school. It is important that the health office has the name of a person who can care for the child in the event that the parents are not available.

If your child has a history of a medical condition which may impact his/her school day, that history may be shared with appropriate school personnel "on a need to know basis" in order to ensure their optimum care while at school. Unless we receive a written statement from you requesting otherwise, your child's name will be included on the confidential Health Concern List.

The health and well-being of your child is of vital importance to us, and we hope that you will carefully go over this letter to make certain that all of the required information is on file as specified. If you have any questions, please do not hesitate to contact us.

Jessica Raba
Assistant Head of School | Principal

Linda Carroll
School Nurse

Long Island Lutheran Middle & High School
131 Brookville Road, Brookville, NY 11545
516.626.1700 | www.luhi.org
A Recognized School of Excellence by the U.S. Department of Education

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HEALTH HISTORY (to be completed by Parent/Guardian)

Student Name (First, Middle, Last) _____

Address (Street, Town, NY, Zip Code) _____

Date of Birth _____/_____/_____ Sex ___ Male ___ Female

Parent/Guardian Name(s) & Phone Number(s) _____

Emergency Contact Name(s) & Phone Number(s) _____

Has your child ever had any of the following? (check all that apply)

- ☐ Allergies (if food allergies, please complete separate food allergy form)
- ☐ Anemia
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Eye Problem
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease or Murmur
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Problem
- ☐ Kidney Disease
- ☐ Prolonged Bleeding
- ☐ Rheumatic Fever
- ☐ Seizures (if so please complete separate seizure form)
- ☐ Stomach Pain
- ☐ Tuberculosis

Please give dates and explanations for any conditions checked above: _____

_____

Since your child's last physical examination, has your child had any of the following? (check all that apply)

- ☐ Taking any medications/under physician's care
- ☐ Feeling of faintness, dizziness, or fatigue after exertion
- ☐ Wears glasses, contacts
- ☐ A surgical procedure/fracture
- ☐ Treatment in a hospital or emergency room
- ☐ Any reason child should not participate in any sport
- ☐ Injury requiring medical attention
- ☐ Illness lasting more than 5 days
- ☐ Any excused absences from Phys. Ed.
- ☐ Any known allergies
- ☐ Any chronic disease
- ☐ Any head injury with or without loss of consciousness

Please give dates and explanations for any conditions checked above: _____

_____

_____ _____/_____/_____

Parent/Guardian Signature Date

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Child's Name: _____

Date: _____

Grade: _____

DENTAL HEALTH FORM

_____ Is in need of dental treatment and is under my care.

_____ Has all necessary dental treatment completed.

_____ Needs no dental treatment at this time.

_____

Signature of Dentist Date

(NOTE: A note on your dentist's letterhead will be acceptable in lieu of this form.)

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REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
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 ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **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 <u>ONLY</u> 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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.