OHR REUVEN אור ראובן

IMPORTANT MESSAGES FROM THE NURSE'S OFFICE

Enclosed you will find all the relevant information needed for the 2017-2018 school year. Please read the information carefully as some information pertains only to certain grades.

Meningococcal Vaccine Requirement (2 DOSES) for Students Entering 12th grade

Students entering 12th grade are required to have received **a total of 2 doses** of the meningococcal vaccine. However, if the 1st dose was given at age 16 or older, then only 1 dose is required.

IMMUNIZATION REQUIREMENTS

All students entering the 12th GRADE and ALL NEW STUDENTS (regardless of their grade) are required to submit a copy of an up-to-date, complete immunization record that meets NYS immunization guidelines.

Documentation of these immunizations must be submitted prior to the start of the school year.

PHYSICAL EXAMS

NY State mandates Health Examinations for **10th GRADE and ALL NEW STUDENTS (regardless of their grade*).*** Please send in a current physical for your child. A physical form dated after 9/1/2016 will fulfill the requirement for the 2017-2018 school year.

HEALTH HISTORY

All NEW STUDENTS are required to fill out a Health History form.

ALLERGIES & MEDICAL INFORMATION

If your son has an allergy (food, insect, latex, etc.) or medical issue, please contact the nurse at nurse@darcheinoam.org and have the appropriate forms filled out and signed by you and your child's Doctor. This will enable the yeshiva to properly care for your child during the school day.

MEDICATION

Medication cannot be administered without a signed authorization from you and your child's Healthcare Provider. This includes all over the counter medications, e.g. Tylenol, Motrin, Benadryl and Tums.
You can find an "Over The Counter Medication Authorization" form on the Yeshiva website and in this packet.
Completing this before the start of school will prevent any inconveniences or delays if your son should need Tylenol, Motrin,...during the school day.

Thank you for you cooperation in assuring YOR's compliance with NYS health laws and mandates.
These requirements were created to keep all students safe and healthy.

Any information requested can be faxed to 845-352-9593

RAMAPO CENTRAL PHYSICAL FORM

(to be completed by private health care provider or school medical director)

Name: _____ **Date of Birth:** ___/___/___ **Gender:** ☐ M ☐ F

School: _____ **Grade:** _____ **Date of Exam:** ___/___/___

Current Diseases: ☐ Asthma ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Hypertension ☐ Hyperlipidemia ☐ Other:_____ (attach emergency care plans)

Significant Medical/Surgical Information:

Physical Examination: ☐ System Review and Exam entirely Normal

☐ Abnormalities: Specify:_____

Height: **Weight:**	**Scoliosis:** ☐ Negative ☐ Positive
BMI: ___ ___ . ____	**Degree of deviation:**
Weight status category (BMI percentile)	**Hearing:** R ____db sc L ____db sc
☐ < than 5th ☐ 5th - 49th ☐ 50th – 84th	**Vision:** R 20/___ L 20/___ distance ☐ with lenses
☐ 85th – 94th ☐ 95th – 98th ☐ > 99th	R 20/___ L 20/___ near ☐ with lenses
BP____/____ **HR** _____ **RR** _____	**Color Perception:** ☐ Pass ☐ Fail
Tanner Stage: I II III IV V	

Immunizations: ☐ Up to date, see attached form ☐ Delayed_____

Labs: U/A _____ **Other Significant:**_____

Tuberculosis : ☐ No risk factors, not indicated ☐ Mantoux result: ___ mm Date: ___/__/___

Medications: _____

Note: Separate Rx needed for all meds to be given in school, including OTC

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

Recommendations or Restrictions for Participation in Physical Education/Sports/Work:

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

☐ Recommendations/restrictions: _____

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 #:** _____

Return to School Nurse : Ramapo Central School District
Yeshivas Ohr Reuven
259 Grandview Ave.
Suffern, N.Y. 10901
Phone: 845-362-8362
Fax: 845-352-9593
EMAIL: businessoffice@ohrreuven.com

Authorization for Medication Form

To Be Filled Out By Physician and Parent

Individual Orders for:
Name:_____
Date of Birth: _____
Weight: _____

The following Standard Over the Counter/PRN medications are available in the Nurse's Office and can be administered at the discretion of the RN (or school administrative staff in RN's absence), if authorized by the student's parent and health care provider.

MEDICATION	ROUTE	DOSE	TIMES TO BE ADMINISTERED	INDICATIONS	COMMENTS
Tylenol					
Motrin					
Benadryl					
Tums					

Student's Physician Name:_____
Address_____
Phone #_____ License #_____
****MD Signature_____ Date_____
****Parent's Signature_____ Date_____