



MEDICAL REQUIREMENTS 2021-2022

Please read the information below carefully. Some requirements were recently updated and some information pertains only to specified grades. **Information about any new medical requirements will be shared as they are made available.**

IMMUNIZATION REQUIREMENTS

Please check with your son's healthcare provider to ensure he has all the **newly required immunizations to attend school.**

PRE-1A • 6th • 7th • 12th and ALL NEW STUDENTS (regardless of their grade)

- Students entering **Pre-1A** are required to have had a 2nd MMR, a 2nd Varicella (chicken pox) Vaccine and a Polio and Dtap after their 4th birthday.
- Students entering **6th grade** are required to have had a 2nd Varicella (chicken pox) Vaccine and a Tdap booster. (The Tdap booster is required by their 11th birthday.)
- Students entering **7th grade** are required to have a Meningococcal Vaccine.
- Students entering **12th grade** are required to have 2 doses of the Meningococcal Vaccine or 1 dose **if** the dose was received after the 16th birthday.
- **ALL NEW STUDENTS** are required to submit an up-to-date, complete immunization record that meets NYS Immunization Guidelines.

HEALTH APPRAISAL/PHYSICAL EXAMS

NYS mandates Health Examinations for the following grades:

KDG • PRE-1A • 1st • 3rd • 5th • 7th • 9th • 11th • and ALL NEW STUDENTS (regardless of their grade)

Please send in a current physical for your child. A physical form dated after 9/1/2020 will fulfill the requirement for this school year.

ALLERGIES & MEDICAL INFORMATION

If your son has an allergy (food, insect, latex, etc.) or medical issue, please contact the school nurse at nurse@ohrreuve.com 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 the "Authorization for Medication" form on the school website. Completing this form before the start of school will prevent any inconveniences or delays if your son should need Tylenol, Motrin...during the school day.

Medical forms (including the NYS compliant Healthy Exam Form, authorization for medication form, allergy forms and NYS Immunization Requirement Chart) are available online:

- Yeshiva Ketana: www.ohrreuve.com/elementary under the parent resources>forms tab
- Mesivta: <http://ohrreuve.com/forms.php>

Please return the completed documentation to the business office by mail, fax (845.352.9593) or email businessoffice@ohrreuve.com.

**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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5 \mu\text{g/dL}$				
<input type="checkbox"/> System Review and Abnormal Findings Listed Below				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
SCREENINGS					
Vision (w/correction if prescribed)		Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK					
<input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____					
<input type="checkbox"/> 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					
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached					
IMMUNIZATIONS					
		<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS	
HEALTH CARE PROVIDER					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form To Your Child's School When Completed.					



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 _____