



Fonda-Fultonville

CENTRAL SCHOOL DISTRICT

August 2023

Dear Parents/Guardians:

We are looking forward to meeting and serving you and your child. As school nurses, we are committed to providing a safe and healthy learning environment for our students. This is only possible with good communication and good working relationships between the faculty/staff and our student's family members.

One step in the goal will be to assure that the school nurse and appropriate staff are aware of any pertinent medical or emotional concerns or needs that your child has that may affect their day at school. For example, a student with a bee sting allergy may need emergency treatment and would benefit from faculty and staff having knowledge of such medical information to ensure your child's safety.

We ask that the Medical History form be completed/updated and supplied to the health office upon entry and yearly thereafter. The information on the Medical History form is utilized as a tool for the health office to gain an understanding of your child's needs to better serve them. A permission form allowing the health office to share medical information with faculty and staff is included for your consent and signature. This will make it possible for the health office to share your child's medical needs on a need to know basis. This information will be kept confidential by those it is shared with.

The NYS requirements for immunizations are detailed in the Immunization and Physical letter. Enclosed is a blank Physical form to be completed by your child's Health Care Provider to include in their individual health record. Physicals for the 2023-2024 calendar year are valid when completed September 2022 through September 2023. If an exam is completed prior to September 2022 and your child is not eligible for an updated physical by their provider, one may be completed by the school physician per the health office schedule.

We will be reviewing your child's medical records, conducting vision and hearing screenings, discussing your child's health history and will be available to answer any questions or concerns you as parents and guardians may have.

Please make every effort to complete and bring with you to your child's registration appointment the following forms: Health History form (in entirety), signature sheet to share information, most recent Immunization and physical with a medication request form. These forms will aid in the review process during your child's registration and are available on the school website, www.fondafultonvilleschools.org.

Please feel free to contact us with any questions prior to registration day.

Sincerely,

Jolyn Bloom, RN
Pre-K-12 School Nurse
(518)853-3332, Ext. 5100
FAX: (518)853-4426
jgiardinobloom@ffcsd.org

Brittney Mancini, LPN
PreK-12 School Nurse
(518)853-3332, Ext. 5101
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District Office

518-853-4415 Ext. 4230
Fax: 518-853-4461
Mr. Thomas Ciaccio
Superintendent of Schools

Business Office

518-853-3732 Ext. 4207
Fax: 518-853-3534
Mrs. Tahatha Biggane
Business Official

High School

518-853-3182 Ext. 4238
Fax: 518-853-1239
Mr. Aaron Grady
Principal

Middle School

518-853-4747 Ext. 4246
Fax: 518-853-4498
Mr. David Zadoorian
Principal

Elementary School

518-853-3332 Ext. 5001
Fax: 518-853-1455
Mr. Eric Romano
Principal

Pupil Services

518-853-4747 Ext. 4234
Fax: 518-853-8643
Mrs. Kristine Dickson
*Director of SPED/Pupil
Personnel*

Curriculum & Instruction

518-853-4747 Ext. 4250
Fax: 518-853-4498
Mrs. Megan Collins
*Director of Curriculum &
Instruction PreK-12*

Student Registration

518-853-4747 Ext. 5008
Fax: 518-853-4498
Mrs. Amy Thum
Data Coordinator

TO: Parents and Guardians

FROM: **Jolyn Giardino-Bloom, RN**
Email: jgiardinobloom@ffcsd.org
Brittney Mancini, LPN
Email: bmancini@ffcsd.org
Phone: (518)853-3332, Ext. 5010 Fax: (518) 853-4426

DATE: Summer 2023

RE: Immunizations & Physical Requirements

The following are required immunizations according to New York State law that every student needs prior to the start of the school year. Immunizations or immunity may be permitted a grace period to attend school for no more than 14 calendar days, or for an individual who is transferring from out of state for no more than 30 days, or by showing proof of appropriate appointments to complete immunizations. Immunization records must be signed by the health care provider according to Department of Health regulations.

Required Immunizations are as follows:

2 MMR (Measles, Mumps, Rubella)

4 or more DTAP's (Diphtheria, Tetanus, Pertussis)

3 Hepatitis B

3-5 Polio

2 Varicella (Chicken Pox) are required for all students Pre-Kindergarten through 12th grades, or history of the disease documented by the Health Care Provider.

****Your doctor's office will follow the Guidelines for Child/Adolescent Immunization Schedule. This schedule can be found on the CDC website.****

<https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>

Pre-K needs the above and:

4 HIB

4 Pneumococcal

Lead Levels (usually obtained at age 1 and 2)

6th-12th grade students need a Tdap booster (usually given between 11 & 12 years old)

7th-12th grade students need Meningitis immunization(s) First dose usually given between 11 & 12 years old and 2nd dose usually given at 16 years old.

New York State requires that all students that are new to the school district and all students in PreK or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade have a physical examination. A physical form is enclosed for the Health Care Provider to complete. Parental permission for authorization for use or disclosure of protected health information (HIPAA) is also included with the physical form. Please return these forms to the health office, as this allows the nurse's to share information with others on a need to know basis. If the forms are left at the doctor's office, please have a stamped envelope with the school's address so the physical may be sent to the school nurse. Your physician may also fax the physical to (518)853-4426. (This is a private fax at the health office that only the school nurses have access to.)

If your child has a physical scheduled during the school year, please notify the Health Office with the date of the scheduled physical exam. **If by October 1st we do not have knowledge of this scheduled physical when one is required, we will schedule it to be done at school.**

A dental health certificate is also enclosed for your dentist/dental hygienist to complete following a dental exam. **It is recommended, but not required, for all new students and those in PreK or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade to have the dental certificate completed.**

If you have any questions or concerns, please call the Health Office at 853-3332, extension. 5010.



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**PROVIDER ATTESTATION AND PARENT/GUARDIAN PERMISSION
REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE**

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry:

I attest this student has demonstrated to me they can self-administer the medication listed below safely and effectively, and may carry and use this medication (with a delivery device if need) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

- ☐ Allergy and requires Epinephrine Auto-Injector
☐ Asthma or a Respiratory Condition that requires Inhaled Respiratory Rescue Medication
☐ Diabetes and requires Insulin, Glucagon and/or Diabetes supplies
☐ _____ which requires rapid administration of _____
(state diagnosis) (medication)

HCP Signature: _____ **Date:** _____

Parent/Guardian Permission for Independent Use and Carry:

I agree that _____ can use their medication effectively and may carry and use this medication independently at school/school sponsored activities. Staff intervention is needed only during an emergency.

Parent Signature: _____ **Date:** _____

Please return this to the school nurses. Contact them with any questions or concerns.

Jolyn Giardino-Bloom, RN

Brittney Mancini, LPN

School Nurses' Office

Telephone: 518-853-3332 Ext. 5010 Fax: 518-853-4426

District Office

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Director of SPED/Pupil
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Mrs. Amy Thum
Data Coordinator

FONDA-FULTONVILLE CENTRAL SCHOOL HEALTH HISTORY

NAME _____ MALE/FEMALE _____ GRADE _____
DATE OF BIRTH _____ PLACE OF BIRTH _____

MEDICAL HISTORY - If your child has had or currently has any of the following please provide specific information with dates:

Allergies _____	Bee Sting Allergy _____	Reaction: _____
Asthma _____	Food Allergy _____	Reaction: _____
Chicken Pox _____	Rheumatic Fever _____	
Ear Conditions _____	Frequent/Chronic Headaches _____	
Seizure Disorder _____	Head Injury _____	
Orthopedic (Bone & Joint) _____	Nosebleeds _____	
Heart Condition _____	Stomach Condition _____	
Operations _____	Serious Injuries _____	
Urinary Tract Problems _____	Pneumonia/Bronchitis _____	
Skin Problems _____	Bowel Problems _____	
Diabetes _____	Dental Problems _____	
Contact with TB _____	Menstrual Problems/Pregnancy _____	

Physical or activity restrictions _____

Medications at Home _____

Medications needed at school _____

(If yes, please request a form from the school nurse - we must have a physician order for all prescriptions and over-the-counter medications.)

Child's Doctor _____ Last seen _____

Doctor's Address and Phone Number _____

Have you ever suspected that your child may have a vision problem? _____

Does he/she wear glasses? _____ Contacts? _____

Has he/she ever been to an optometrist or specialist? _____

If so, what was the result of the exam and recommendations, if any? _____

Have you ever suspected that your child may have a hearing problem? _____

Has he/she ever had a hearing test? _____ DATE _____

If so, what was the result of the exam and recommendations, if any? _____

NYS Education Department requires a physical exam for new students and students in PreK or K, 1, 3, 5, 7, 9 & 11; annually for sports; working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE). This exam is valid for one year through the last day of the dated month with the exception of any illness or injury lasting more than five days that will negate the exam.

Please indicate if you prefer the exam to be performed by your family physician. _____

Parent needs to send a copy of the physical to the School Nurse. Please inform the nurse of the physical date by October 1 or one will be done by the school physician.

I agree to emergency medical treatment as deemed necessary by school authorities.

DATE: _____ PARENT/GUARDIAN SIGNATURE _____

Fonda-Fultonville Central School
School Nurses' Office
112 Old Johnstown Rd.
P.O. Box 1501
Fonda, New York 12068
Telephone: (518)853-3332, Ext. 5010 or 4226
Fax: (518) 853-4426

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) listed below to release my
child's _____ medical records to the district's medical office, physical (PT), occupational (OT),
speech
therapists (ST) and/or school nurse:

Name _____	Phone _____	Fax _____
Name _____	Phone _____	Fax _____
Name _____	Phone _____	Fax _____
Name _____	Phone _____	Fax _____

The healthcare provider may disclose the following protected health information: (check all that apply)

- ☐ Immunizations
- ☐ Health Appraisals
- ☐ Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST needs
- ☐ Other

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- ☐ To develop care or therapy plans for routine and emergent school management
- ☐ To design appropriate educational programs
- ☐ To assess the impact of the medical condition(s) on school programming and/or attendance
- ☐ To share school observations/concerns surrounding behavior
- ☐ To assess a medical basis for modification of transportation and/or home tutoring
- ☐ Medication delivery and/or therapy prescriptions for PT, OT, ST
- ☐ At patient's request with no specified purpose
- ☐ Other

Please select one:

- ☐ This authorization is valid for the entire academic school year 20 - 20



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MEDICATION REQUEST FORM

Student's Name: _____

Grade and Homeroom: _____

School nurses are **not** able to medicate students without a written order from a health care provider or your permission. This includes both prescription and over the counter medications. Even if your child does not take a routine medication, this form will allow the health office to medicate students with as needed medications, example: Tylenol for headache. We ask that you provide the following:

1. A written note from you, the parent or guardian. (Part I below).
2. A written order from your health care provided including the information shown on this form (Part II below).
3. A new health care provider's order for any new medication, change in medication dosage, time of medication administration.
4. A new medication order at the beginning of each school year.
5. The medication is brought to school by an adult in the prescription bottle or original packaging if it is an over the counter medication.

Students are not allowed to carry medications on their person or take medication without written directives from the student's health care provider and parent/guardian. When students are required to take any medication in school, it must be administered under supervision.

Part I: TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN

I hereby give permission for the medications to be administered to my child as stated below:

Student Name and Birth Date: _____

Parent Signature and Contact Number: _____

Date: _____

Part II: TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

Student Name and Birth Date: _____

Medication Name and Reason: _____

Dosage, Frequency, and Route of Medication: _____

Possible Side Effects: _____

Health Care Provider's Signature: _____

Date: _____ Contact Number: _____

Please contact the nurses' office with questions. 518-853-3332 ext. 5010 Fax 518-853-4426

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