Fonda-Fultonville
CENTRAL SCHOOL DISTRICT

A Legacy of Families First

March 2024

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 2024-2025 calendar year are valid when completed September 2023 through September 2024. If an exam is completed prior to September 2023 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 Giardino-Bloom, RN	Brittney Mancini, LPN	Abbigail Furman, LPN
(518)853-3332 Ext.5100	(518)853-3332 Ext. 5101	(518)853-3332 Ext. 5010
Fax: (518)853-4426	Fax: (518)853-4426	Fax: (518)853-4426
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Fax. 518-853-1239
Mr. Aaron Grady
Principal

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Fax: 518-853-4498
Mr. David Zadoorian
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Mr. Eric Romano
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Pupil Services
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Curriculum & Instruction
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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
Abbigail Furman, LPN
Email: afurman@ffcsd.org
Phone: (518)853-3332, Ext. 5010 Fax: (518) 853-4426

DATE: March 2024

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.

Fonda-Fultonville
CENTRAL SCHOOL DISTRICT

A Legacy of Families First

School Nurses' Office
Telephone: 518.853.3332, extension 5010 Fax: 518.853.4426

Health Information

Dear Parents and Guardians:

Each year students enter Fonda-Fultonville Central School in grades PreK-12 with their own unique personalities and individual needs. The nurses' office, located in the Elementary School, serves all students' health care needs from basic first aid to long term illness and conditions.

In order to best serve your child, we are asking that you provide the school nurses with health information, such as allergies or medications he or she may take, so we can appropriately care for your child. The information may be shared with teaching staff, support, staff, kitchen staff, and bus drivers on a need to know basis. It may be essential the information be shared so that, in an emergency, our staff can react quickly and appropriately (example: a student has a bee allergy and carries an EPI pen).

It is important that the nurses are aware of any medications or treatments, whether they are new, have changed, or are not being given at school. Any recent injury, infection, illness, or change in health condition is important to relay to the school nurses as well. Information shared with the nurses does not need to be limited to an emergency; it may simply be letting us know your child is returning to school after recovering from the flu.

If you have any questions or concerns, please contact us.. We look forward to providing a safe and healthy environment for your child.

It is your right to inform us at any time that the information listed should no longer be shared. You may return this form to the nurses' office in a sealed envelope to maintain privacy.

Sincerely,

Jolyn Giardino-Bloom, RN *Brittney Mancini, LPN*

Student Name:_____ **Grade:**_____ **Homeroom:**_____

Please list all recent and previous health concerns: _____

_____

_____

_____

_____

Please check one:

☐ I give permission for the nurses to share appropriate health information on an as needed basis.
☐ I do not give permission for the nurses to share health information.

Parent Signature:_____ **Date:**_____

District Office
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Fax: 518-853-4161
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Principal

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HEALTH HISTORY

NAME:_____ **SEX:**_____ **GRADE:**_____
DATE OF BIRTH:_____ **PLACE OF BIRTH:**_____

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

Allergies:_____ Bee Sting Allergy and Reaction:_____
Asthma:_____ Food Allergy and Reaction:_____
Diabetes:_____ Seizure Disorder:_____
Head Injury:_____ Frequent/Chronic Headaches:_____
Heart Condition;_____ Nose Bleeds:_____
Ear or Eye Condition:_____ Dental Condition_____
Pneumonia/Bronchitis_____ Contact with TB:_____
Stomach Condition:_____ Bowel Problems:_____
Urinary Tract Problems:_____ Menstrual Problems/Pregnancy:_____
Skin Problems:_____ Chicken Pox:_____
Bone and Joint:_____ Rheumatic Fever: _____
Serious Injuries or Operations:_____
Health Concern not mentioned:_____

Physical activity restrictions:_____
Medications at home:_____
Medications needed at school:_____
(Please fill out the Medication Request Form. We must have a healthcare provider order for all prescriptions and over the counter medications).

Child's Health Care Provider:_____ Last seen:_____
Health Care Provider's Address and Phone Number:_____
_____

Does your child have a known or suspected vision problem?_____
Does your child wear glasses or contact lenses? _____
Has your child been to an optometrist or specialist, if so, when?_____
If yes, what were the recommendations, if any?_____

Does your child have a known or suspected hearing problem?_____
Has your child had a hearing test, if so, when?_____
If yes, what were the recommendations, if any?_____

Please indicate if you prefer the exam to be performed by your healthcare provider. _____
Parents need to send a copy of the physical to the nurses or a physical will be done at school.
Please inform the nurses of a physical by October 1st.
I agree to emergency medical treatment as deemed necessary by school authorities.

Parent/Guardian Signature and Date:_____

Please contact the nurses' office with any questions. Phone 518-853-3332 ext. 5010 Fax:518-853-4426
Jolyn Giardino-Bloom, RN jgiardinobloom@ffcsd.org
Brittney Mancini, LPN bmancini@ffcsd.org
Abbigail Furman, LPN afurman@ffcsd.org

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

❑ This authorization shall expire on ___/___/___ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that revoking this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

1 understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date **Signature of Patient (Over 18), Parent, Guardian** **Relationship**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child

MEDICATION REQUEST FORM

Student's Name: _____
Grade and Homeroom: _____

School nurses are **not** able to medicate students without a written order from a physician 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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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 needed) 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.

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