



# Fonda-Fultonville

## CENTRAL SCHOOL DISTRICT

September 2024

Dear Parents and Guardians,

We look forward to taking care of your child for the upcoming school year! As school nurses, we are committed to providing a safe and healthy learning environment for our students. One way we are able to provide this environment is for you to share with us pertinent health concerns that your child may have that could affect your child's school day (a bee sting allergy that needs to be treated with Benadryl).

We ask that you complete and/or update this health history and return it to the health office. The information provided is shared with staff, with your permission, in our School Tool system. A permission form to share healthcare information has been provided to you in this packet. We will only share this information on a need to know basis.

We have included the NYS requirements for immunizations. If the health office does not receive an updated record of immunizations, a student may not be able to attend school. A 14 day grace period is provided to current students and a 30 day grace period is provided to those new in the district. Your healthcare provider may provide you with a copy of immunizations to bring in, or send it to us by either email or the address or fax number below. The fax number and email is confidential. Immunizations - All students need 2 MMR, 4 or more DTP, 3 Hepatitis B, 3-5 Polio, and Varicella (students K-12 need 2 doses or proof of disease) vaccinations. Pre-K students also need 4 HIB, 4 Pneumococcal vaccinations and 2 lead levels. Grades 6-12 need a Tdap booster and 7-12 need to be vaccinated against meningitis. All required immunizations can be found at: <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>

Physicals for the 2024-2025 school year are valid from September 3, 2023 and after. Students in Pre-K, K, 1st, 3rd, 5th, 7th, 9th, and 11th grade need an updated physical, as well as any student grade 7th - 12th playing a sport. Physical forms are located in the Health Services link on the school's website. If your child meets the criteria above for a physical, and one is not provided to the health office by October 1st, we will provide an exam at the school. Your healthcare provider may provide you with a copy of the physical to bring in, or send it to us by email or the address or fax number below. The fax number and email is confidential.

A dental health certificate is available on the Health Services link on the school website. This form is recommended, but not a requirement, for students in Pre-K, K, 1st, 3rd, 5th, 7th, 9th, and 11th grade. Your dentist or hygienist can complete this form and may provide you with a copy to bring in, or send it to us by email or the address or fax number below. Again, the fax number and email is confidential.

For students in pre-kindergarten and kindergarten, please bring all completed health forms to your child's registration appointment. For registration, we will review your child's medical records, discuss the student's health history, and conduct hearing and vision screenings. We will be available to answer any questions you may have.

For returning students, please return forms as soon as they are completed. We will review student records as they are received and will reach out to you with questions or concerns. Please know you may contact us anytime.

All forms needed for students can be found at [www.fondafultonvilleschools.org](http://www.fondafultonvilleschools.org) under the Health Services link.

Sincerely,

Jolyn Bloom, RN  
[jiardinobloom@ffcsd.org](mailto:jiardinobloom@ffcsd.org)  
Phone: (518)853-3332, ext: 5010

Brittney Mancini, LPN  
[bmanicini@ffcsd.org](mailto:bmanicini@ffcsd.org)  
Fax: (518)853-4426

Abigail Furman, LPN  
[afurman@ffcsd.org](mailto:afurman@ffcsd.org)

*A Legacy of  
Families First*

### **District Office**

518-853-4415 Ext. 4230  
Fax: 518-853-4461  
Richard R. DeMallie, Ed. D.  
*Superintendent of Schools*

### **Business Office**

518-853-3732 Ext. 4207  
Fax: 518-853-3534  
Mrs. Jodie Rodriquez  
*Interim Business Official*  
Mrs. Chasity McGivern  
*School Business Manager*

### **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. Kyle Roberts  
*Interim 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*

### **K-12 Programs**

518-853-4747 Ext. 4250  
Fax: 518-853-4461  
Mrs. Christine Radez  
*Director of Curriculum & Instruction*

### **Student Registration**

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

## HEALTH HISTORY

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

**MEDICAL HISTORY:** If your child had or currently has any of the following, please check the box, and provide pertinent information on the back of this page.

Allergies: ☐ Bee Sting Allergy: ☐ Food Allergy: ☐ Asthma: ☐ Diabetes: ☐  
 Seizure Disorder: ☐ Head Injury: ☐ Frequent/Chronic Headaches: ☐ Ear Condition: ☐  
 Eye Condition: ☐ Glasses or Contacts: ☐ Heart Condition: ☐ Nose Bleeds: ☐  
 Dental Condition: ☐ Pneumonia/Bronchitis: ☐ Contact with TB: ☐ Chicken Pox: ☐  
 Stomach Condition: ☐ Bowel Condition: ☐ Urinary Tract Condition: ☐  
 Skin Condition: ☐ Bone and Joint: ☐ Rheumatic Fever: ☐ Serious Injury/Operation: ☐  
 Health Concern not mentioned: ☐ Physical Activity Restrictions: ☐

Medications at home: ☐ Medications at School: ☐

**\*\*\*For all medications provided in school, prescription or over the counter, a provider order and the Medication Request form need to be filled out.\*\*\***

Health Care Provider: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Health Care Provider's Address and Phone Number: \_\_\_\_\_

Eye Doctor: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Recommendations: \_\_\_\_\_

Ear, Nose, & Throat Doctor: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Recommendations: \_\_\_\_\_

Please check, if you prefer your child's health exam to be performed by your own provider \_\_\_\_\_.

A copy of the health exam needs to be sent in to the Health Office. **If no record of a physical is obtained by October 1st, a physical will be completed at school.**

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

**Parent/Guardian Signature & Date:** \_\_\_\_\_

☐ I give permission for the nurses to share appropriate health information on an as needed basis.

☐ I do **NOT** give permission for the nurse to share health information.

**Parent/Guardian Signature and date:** \_\_\_\_\_

Please reach out to the nurses with questions or concerns, Phone: 518-853-3332, ext. 5010 Fax: 518-853-4426

Jolyn Bloom, RN      Brittney Mancini, LPN      Abigail Furman, LPN

jgiardinbloom@ffcsd.org      bmancini@ffcsd.org      afurman@ffcsd.org

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Fax: 518-853-4498  
Mrs. Amy Thum  
*Data Coordinator*

P.O. Box 1501, 112 Old Johnstown Road, Fonda, New York 12068-1501 ■ [www.fondafultonvilleschools.org](http://www.fondafultonvilleschools.org)

**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 medical officer, school nurse, physical (PT), occupational (OT), speech (ST) therapists:

Name: _____	Phone#: _____	Fax#: _____
Name: _____	Phone#: _____	Fax#: _____
Name: _____	Phone#: _____	Fax#: _____

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

☐ Immunizations  
☐ Health Appraisals  
☐ Current/Past Medical Conditions 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 educations programs  
☐ To assess the impact of the medical condition 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 for no specific purpose  
☐ Other \_\_\_\_\_

Please select one:

☐ This authorization is valid for the entire academic year 20\_\_\_\_ - 20\_\_\_\_  
☐ This authorization shall expire on \_\_\_\_/\_\_\_\_/20\_\_\_\_

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

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

I 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 state or federal law.

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

_____ Signature of patient (over 18) or parent/guardian	_____ Relationship	_____ Date
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\*A signed copy of this authorization must be given to the adult patient or parent/guardian of the minor child.\*

Please contact the school nurses' with questions or concerns, phone: 518-853-3332 ext. 5010 fax: 518-853-4426

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[jgiardinobloom@ffcsd.org](mailto:jgiardinobloom@ffcsd.org)

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[bmancini@ffcsd.org](mailto:bmancini@ffcsd.org)

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**MEDICATION REQUEST FORM**

**Student's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

School nurses are **not** able to medicate students without a written order from a provider and/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 of the nurses.

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

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

Student Name and Birth Date: \_\_\_\_\_

Parent/Guardian 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: \_\_\_\_\_

Healthcare 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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