Fonda-Fultonville CENTRAL SCHOOL DISTRICT

A Legacy of Families First

August 2025

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.health.ny.gov/publications/2370_2026.pdf

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 under the Health Services link.

Sincerely,

Jolyn Bloom, RN
jgiardinobloom@ffcsd.org
Phone: (518)853-3332, ext: 5010

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

Abbigail Furman, LPN
afurman@ffcsd.org

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

Business Office
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Interim Business Official
Mrs. Chasity McGivern
School Business Manager

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Fax: 518-853-1239
Mr. Aaron Grady
Principal

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Mr. Kyle Roberts
Interim Principal

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Director of Curriculum & Instruction

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Mrs. Amy Thum
Data Coordinator

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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	Abbigail Furman, LPN
jgiardinbloom@ffcsd.org	bmancini@ffcsd.org	afurman@ffcsd.org

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Further Explanation of Health History or Medical Concerns:

_____

_____

_____

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_____

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

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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

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

Jolyn Giardino-Bloom
jgiardinobloom@ffcsd.org

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Abbigail Furman, LPN
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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: _____

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