GREAT NECK PUBLIC SCHOOLS
Health Services
Immunization Record

NAME_____DOB_____SCHOOL_____

ADDRESS_____PHONE_____GRADE____TEACHER_____

Under section 2164 of the New York State Public Health Law, all children attending school,… or any preschool program must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, Varicella, Meningococcal, Haemophilus Influenza b & Prevnar. Children who attend a preschool…must also show evidence of lead screening.
Please have your Health Care Provider fill in **Month, Day & Year of ALL Immunizations. ALL DATES ARE REQUIRED**.

Your child <u>may not</u> attend school without this information.

*****PLEASE CHECK WITH YOUR DOCTOR FOR THE REQUIRED DOSES FOR YOUR CHILD ACCORDING TO ACIP GUIDELINES*****

- **DTaP → <u>3-5 Doses Required</u>** {Must have 1 Dose give AFTER age 4, prior to Kindergarten}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___
- **Tdap→ <u>1 Dose Required</u>** {Mandatory Grades 6th -12th} **AND ALSO**{Depending on Age & Grade}
  1. ___/___/___
- **IPV → <u>3-5 Doses Required</u>** {Must have 1 Dose give AFTER age 4, prior to Kindergarten}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___
- **HBV (HEPATITIS B)→ <u>3 Doses Required</u>**
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ Additional Doses: ___/___/___ ___/___/___ ___/___/___
- **MMR→ <u>2 Doses Required</u>** {1st Dose Must be give on or After First Birthday. 2nd dose Required for Kindergarten.}
  MMR: 1. ___/___/___ 2. ___/___/___
  Or MEASLES: 1.___/___/___ 2. ___/___/___ MUMPS 1. ___/___/___ 2.___/___/___ RUBELLA 1. ___/___/___ 2.___/___/___
- **VARICELLA VACCINE (CHICKEN POX)→ <u>2 Doses Required</u>** {1st Dose Must be give on or After First Birthday. 2nd dose Required for Kind., 1st & 2nd Grade}
  1. ___/___/___ 2. ___/___/___ <u>Or proof of Disease from Health Care Provider</u>→ DATE: 1. ___/___/___
- **MENINGOCOCCAL VACCINE→ <u>1-2 Doses Required</u>** {1st Dose Required for 7th & 12th Grades}
  1. ___/___/___ 2. ___/___/___

<u>For children entering Preschool program</u>

- **Hib (HAEMOPHILUS INFLUENZA b)→ <u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
- **PREVNAR (PCV) → <u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
- **LEAD SCREENING →<u>Required for Preschool</u>** → ___/___/___ → _____

<u>Optional Vaccines</u>

- **HEPATITIS A Vaccine (HAV)→** 1. ___/___/___ 2. ___/___/___
- **HUMAN PAPILLOMAVIRUS (HPV)→** 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
- **PPV (Pneumococcal Polysaccharide Vaccine) →** 1. ___/___/___ 2. ___/___/___
- **ROTATEQ→** 1. ___/___/___ 2. ___/___/___ 3. ___/___/___
- **OTHER VACCINES: _____→** 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

➢ PPD/TB TEST→ ___/___/___ Read ___/___/___ → _____ mm → Result: N___ P___

Children who have not been immunized may be admitted <u>with 1 Dose of **each required vaccine series</u> & has **WRITTEN** age appropriate appointments to complete the series according to the ACIP guidelines.**

<u>**PHYSICIAN'S SIGNATURE**</u>, <u>**STAMP**</u>, ADDRESS, PHONE NUMBER

_____

_____

_____

DATE: ___/___/___

GREAT NECK PUBLIC SCHOOLS
HEALTH SERVICES

Physical Examination

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires a physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: ☐M ☐F

School: Grade: ☐No Grade Exam Date:

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma:** ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes:** ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures** Type: _____ Last Occurrence: _____ ☐Emergency Care Plan Attached

☐**Allergies:** ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Allergen(s):

☐Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th

☐ 5th - 49th ☐ 95th - 98th

☐ 50th - 84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): **Tanner:** ☐I ☐ II ☐III ☐IV ☐ V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

- ☐ **No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
- ☐ **Other Specific Restrictions:**

Accommodations / Protective Equipment:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	☐Pacemaker
	☐Brace/Orthotic	☐Medical /Prosthetic Device	☐Sports Safety Goggles
	☐Hearing Aides	☐Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____ _____

_____ _____

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

☐ **Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature:

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: ( ) _____

Provider Address: _____ Fax #: ( ) _____

Medical Provider's Stamp	**School Doctor Co-Sign**
	_____ **Date**_____