



## Broome Tioga BOCES Health Office/Related Services RETURN TO SCHOOL ORDERS PROTOCOL

According to the American Academy of Pediatrics certain criteria warrant a note from a student's health care provider when a student returns to school following such events as, but not limited to; **an extended illness (an illness lasting 5 days or greater), hospitalization, new diagnosis of a significant health condition, orthopedic injury, surgery, stitches, when there is a question about implications of a diagnosis for others in the school or when there is a question about a care plan for a child who may require special accommodations such as an excuse from physical education or recess.**

The note is required prior to the student's return to school.

### Extended Illness:

- A note is required from the healthcare provider when there is a question about the implication of a diagnosis for others in the school and/or a care plan for a child who may require special accommodations.

### Orthopedic Injuries and Orthopedic Devices

(Including, but not limited to, casts, braces, splints, slings or crutches):

- A note is required clearing the student's return to school, advising the school as to the progression of activity allowed after an orthopedic injury and any restrictions or accommodations needed in the school setting.

### Surgery:

- A note is required when a student is returning following a surgical procedure, especially if there is limited movement around the site of the surgical incision.

### Stitches:

- A note is required when a student with stitches will be excused from physical education or recess until the stitches are removed.





**RELEASE OF MEDICAL INFORMATION**

In the case of: \_\_\_\_\_  
*(Name of Child)*

\_\_\_\_\_ *(Date of Birth)*

I Hereby Authorize and Request you (Provider's/Practice's name: \_\_\_\_\_) to release the following information (Please list specific information; i.e. Physical exam, medication orders, immunization information, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**to:** Broome-Tioga BOCES – Health Office  
435 Glenwood Road  
Binghamton, NY 13905-1699

**For the purpose of** continuing care during school hours.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_

I Hereby Authorize and Request Broome-Tioga BOCES to release any and all information of the above mentioned minor **to the following organization(s)**: (Examples: Probation, Social Services)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Student





Education Center Health Office 607-763-3411 Fax 607-763-3363  
 West Learning Center 607-786-2021 Fax 607-748-8616  
 East Learning Center 607-762-6408 Fax 607-762-6407

**Authorization for Medication Administration at School  
 2021-2022 School Year**

**To be completed By Parent/Guardian:**

I request that my child \_\_\_\_\_ DOB \_\_\_\_\_ receive the medication as prescribed below by our physician. (The medication is to be furnished in the original, properly labeled container from the pharmacy).

**PLEASE CHECK ONE:**

\_\_\_\_\_ I understand that my **Independent Student** may self-carry and self-administer emergency rescue medications such as inhalers, epi pens, and diabetes medications without any assistance.

\_\_\_\_\_ I understand that the school nurse, or other designated person in the nurse's absence, will assist with administration of the medication, including field trips, to my **Supervised Student**.

\_\_\_\_\_ I understand that administration of oral, topical, inhalant or injectable medications to my **Nurse Dependent Student** must remain the responsibility of the school nurse or licensed practical nurse under the direction of a school nurse, physician or parent.

Signature (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

**\*Medication must be in original pharmacy labeled container with specific orders and name of medication.**

**\*Medication and refills must be brought to school by a parent, guardian or responsible adult.**

**To be completed by Physician**

I request that my patient, listed below, receive the following medication:

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	INDICATION	POSSIBLE ADVERSE EFFECTS	DOSE	FREQUENCY/TIME	DURATION	ROUTE

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (Printed): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**check box if medication orders may be applied to summer school following current school year.**



**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR  
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

**Risk Factors for Diabetes or Pre-Diabetes:** Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI \_\_\_\_\_ kg/m2

**Percentile (Weight Status Category):**  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

**Hyperlipidemia:**  No  Yes  Not Done      **Hypertension:**  No  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</b>
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5 \mu\text{g/dL}$				
<input type="checkbox"/> <b>System Review and Abnormal Findings Listed Below</b>				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision</b> (w/correction if prescribed)		<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening		<input type="checkbox"/> Pass <input type="checkbox"/> Fail			<input type="checkbox"/>
Notes					
<b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
Notes					
<b>Scoliosis</b> Screen Boys in grade 9, and Girls in grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____					
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
		<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS	
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					