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 stiches 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
2022-2023 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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

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

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing 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.			**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, 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.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.