

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

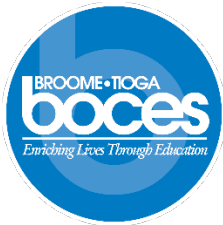
Relationship to Student

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

East Learning Center (607)762-6408 Fax (607)762-6407

West Learning Center (607)786-2021 Fax (607)748-8616

Authorization for Medication Administration at School 2024-2025 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 HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<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
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	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): < 5th 5th- 49th 50th- 84th 85th- 94th 95th- 98th 99th and >

Hyperlipidemia: Yes Not Done **Hypertension:** Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<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/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<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:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<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					
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					