DAYTON AVENUE SCHOOL

151 Dayton Avenue • Manorville, New York 11949 • (631) 801-3080 • Fax (631) 878-6404 • www.esmonline.org

JOSEPH A. STEIMEL
Superintendent of Schools

SHELITA WATKIS, PH.D
Principal

Dear Parents and Guardians,

I hope you are enjoying your summer. I wanted to send out a few reminders of what will be required upon our return in September. I will be monitoring any guidelines that will be set forth by the NYS Department of Health. In the meantime, please read this letter and see any attachments that may be applicable to your child for the 2021-2022 school year. Please send all required documentation to the Dayton health office before the start of the new school year.

Medical changes/updates

- **Please complete the Health History form on an annual basis for all students.**

Please notify the school nurse if any of the following conditions apply to your child:

- If your child has a food allergy, asthma, seizure disorder, diabetes or other medical conditions.
- If your child experiences an urgent care/ ER visit, sprain, fracture, surgery, an addition to or change in medications, or has a new diagnosis.

Physicals

Physicals are required if you are a new student **or entering Pre-K, kindergarten, 1st, 3rd, 5th, 7th, 9th, and 11th grades**. Any physical dated from **9/8/2020** and after will be accepted for the 2021-2022 school year. **Please print a copy of the physical exam form to be completed by your doctor**. If you do not submit a physical for your child, they will be examined by the school's physician, at no cost to you, during school hours. Dental forms are requested and preferred but not a NYS requirement. **You can print a dental form to be completed by your dentist.**

Immunizations

- NYS requires immunizations and a record needs to be provided prior to the first day of school. **Please see the immunization requirements specific to our building grade levels.**
- ***6th grade students that have turned 11 years old must have their Tdap vaccine prior to the first day of school.***
- If your child is on a delayed immunization schedule, please submit a note from your MD with upcoming appointments that are congruent with NYS catch-up vaccine schedule.
- If your child has a medical exemption, please contact the school nurse to have proper documentation completed by your MD.

Medications in School

NYS requires a MD order for all medications including prescription and over the counter medications, such as cough drops, creams, eye drops, Tylenol or Motrin. A copy of this medication form and an Emergency Care Plan, if applicable, has already been sent home if they were on medications this past year. **If you need another copy, please print an order form to be completed. Please also see our medication administration requirement form for any questions regarding medications**.

Allergies

Our building is "Allergy Aware" meaning **NO peanut or tree nut items are permitted inside Dayton**. This includes Peanut butter and Nutella. Other types of food allergies have been increasing in the past few years and further restrictions may be placed in specific classrooms. You will receive notification if this applies to your child's class.

I hope everyone is having a safe, wonderful, and healthy summer! I look forward to seeing everyone again in September!!

Warmly,

Linda Grosskopf, RN
Dayton Ave School Nurse
631-801-3090
Fax- 631-878-6404
grosskopfl@esmonline.org

DAYTON AVENUE SCHOOL

151 Dayton Avenue • Manorville, New York 11949 • (631) 801-3080 • Fax (631) 878-6404 • www.esmonline.org

JOSEPH A. STEIMEL
Superintendent of Schools

Eastport - South Manor ESM Central School District

SHELITA WATKIS, PH.D
Principal

August, 2021

Dear Sixth Grade Parent/Guardian:

The New York State Department of Health regulations for immunizations are:

All students entering Sixth grade will require 2 doses of the Varicella (chicken pox) vaccine, 4 doses of IPV (Polio) and a booster immunization containing tetanus toxoids, diphtheria and acellular pertussis (Tdap) .

If your child has received a Tdap before the age of 10 years old, please consult your family doctor for the proper schedule for immunization, because the vaccine will have to be repeated.

Exemptions from the new requirement for varicella vaccine include the following;

- A history of varicella disease as documented by a health care provider. Parental recall of this disease history is not sufficient, and will not be accepted as proof of immunity.
- A medical exemption consisting of a written statement from a physician licensed to practice in the State of New York stating there is a valid medical contraindication to varicella vaccine. All medical exemptions must be renewed annually. A copy of the exemption must be retained by the school.

Except as provided above, students who are not properly immunized as outlined by the New York State Department of Health will be excluded from school (see Public Health Law 2164 section 7(a)).

This law applies to in-person and remote learners.

Please provide proof of the above immunization requirements to the school nurse prior to the first day of school in September 2021.

If you have any questions about immunization requirements, please call the School Nurse in the building your child attends.

Sincerely,

William Madsen
Director of Health, Physical Education and Athletics

Linda Grosskopf, RN
School Nurse
631-801-3090
Fax:631-878-6404

Cc: Building Principals

EASTPORT-SOUTH MANOR CENTRAL SCHOOL DISTRICT
149 Dayton Avenue, Manorville, NY 11949

NAME OF CHILD: _____

HEALTH HISTORY INFORMATION

Has your child ever had any of the following? ☐ Yes ☐ No

☐ Pneumonia	☐ Whooping Cough	☐ Tonsillitis
☐ Tuberculosis	☐ German measles	☐ Frequent Colds
☐ Rheumatic Fever	☐ Asthma	☐ Hearing Loss
☐ Epilepsy	☐ Diabetes	☐ Vision Problems
☐ Chicken Pox	☐ Anemia or Sickle Cell	☐ Heart Trouble
☐ Measles	☐ Mononucleosis	☐ Skin Disorder
☐ Mumps	☐ Kidney Trouble	☐ Hernias

Is there anything concerning the eyes, ears, or health of this child which the school should know in order to provide special care?

_____

_____

ALLERGY SCREENING

If your child has an allergy (such as food, medication, or environmental) please answer the following questions:

1. Is your child allergic to anything? ☐ YES ☐ NO
   Please include any food, medication or environmental allergies
   Please specify allergen and your child's reaction (i.e. hives, rash, shortness of breath, etc.): _____
   _____
   _____
2. Does your child have a prescribed EpiPen for this allergy? ☐ YES ☐ NO
3. Is your child at risk for a life-threatening allergic reaction? ☐ YES ☐ NO
4. Has your child's allergy been identified through allergy testing? ☐ YES ☐ NO
5. Please check circumstances which reaction could occur: ☐ Contact ☐ Ingestion ☐ Airborne

ASTHMA

If your child has asthma, please answer the following questions:

1. Does your child have asthma? ☐ YES ☐ NO
2. Does your child use an inhaler or a nebulizer at home? ☐ YES ☐ NO
3. Will medication be required for use during school hours? ☐ YES ☐ NO

Parent Signature: **Date:**

Please Complete Side Two

NAME OF CHILD: _____

ILLNESS, INJURY OR OPERATION

Has your child, during the past year had any illness, injury or operation? If so, please write name and date of illness below.

_____

_____

_____

MEDICATIONS

Please list any medications your child is presently taking.

_____

_____

_____

*If your child's physician requires an over the counter medication or prescription medication during school hours, a doctor's order along with parent/guardian consent must be obtained.

- **The medication must be brought to school by a parent/guardian in the original container.**
- **Medication cannot be transported on the school bus.**

In the event of an emergency where a parent cannot be reached, I give permission for my child to receive medical treatment.

Parent Signature: **Date:**

PHYSICAL EXAMINATION

A physical examination by a private physician or the school physician, on entry of school and routinely at **grades PreK or K, 1, 3, 5, 7, 9, & 11 is compulsory.**

Please check the appropriate item:

_____ I wish to have my child examined by the family physician at my expense and will submit a report to the school by October 15th or 30 days after entry for students newly enrolled in the district. **If the results of your child's examination have not been received by this date, the school physician will examine your child.**

_____ I wish to have my child examined **without cost** by the school physician.

Parent Signature: **Date:**

Eastport-South Manor Central School District

149 Dayton Avenue • Manorville, New York 11949 • (631) 801-3000 • Fax (631) 874-6750 • www.esmonline.org

JOSEPH A. STEIMEL
Superintendent of Schools

ADAM FRANKEL
Assistant Superintendent for Curriculum and Instruction

TIM LAUBE
Assistant Superintendent for Business & Operations

LINDA ANNE WEISS
Assistant Superintendent for Personnel & Student Services

Immunization Requirements for Grades 7th - 12th

Immunization	Number of doses
DTaP/ DTP	**3 doses**
Tdap	**1 dose**
Polio	**4 doses** or **3 doses** if 3rd dose given at 4 years of age or older
Hepatitis B	**3 doses**
MMR	**2 doses**
Varicella	**2 doses**
Meningococcal	**Grade 7: 1 dose** (given after age 10) **Grades 8-11: 1 dose** **Grade 12: 2 doses** (1 dose after age 16)

Proof of immunization must be any **1 of the 3** items listed below:

- An immunization certificate signed by your health care provider
- Immunization Registry report (NYSIIS or CIR from NYC) from your health care provider or your county health department
- A blood test (titer) lab report that proves your child is immune to Hepatitis B, MMR, or Varicella. For Varicella (chickenpox), a note from your health care provider (MD, NP, PA) which says your child had the disease is also acceptable.

Eastport-South Manor Central School District

149 Dayton Avenue • Manorville, New York 11949 • (631) 801-3000 • Fax (631) 874-6750 • www.esmonline.org

JOSEPH A. STEIMEL
Superintendent of Schools

ADAM FRANKEL
Assistant Superintendent for Curriculum and Instruction

TIM LAUBE
Assistant Superintendent for Business & Operations

LINDA ANNE WEISS
Assistant Superintendent for Personnel & Student Services

Immunization Requirements for Elementary Grades Pre-K – 6th

Pre-Kindergarten

Immunization	Number of doses
Polio	**3 doses**
Hepatitis B	**3 doses**
Diphtheria/Tetanus/Pertussis (DTaP)	**4 doses**
Measles/Mumps/Rubella	**1 dose**
Varicella (Chicken Pox)	**1 dose**
Hemophilus Influenzae	**1-4 doses**
Pneumococcal Conjugate	**1-4 doses**

Kindergarten & Grades 1-6

Immunization	Number of doses
Polio	**4 doses** or **3 doses** if 3rd dose given at 4 years of age or older
Hepatitis B	**3 doses**
Diphtheria/Tetanus/Pertussis (DTaP/DTP)	**5 doses** or **4 doses** if 4th dose given at 5 years of age or older or 3 doses if 7 years or older & series started at age 1 or older
Tdap	**Age 11:** Must receive an immunization containing tetanus toxoids, diphtheria, and acellular pertussis (Tdap)
Measles/Mumps/Rubella	**2 doses**
Varicella (Chicken Pox)	**2 doses**

Proof of immunization must be any 1 of the 3 items listed below:

- **An immunization certificate signed by your health care provider**
- **Immunization Registry report (NYSIIS or CIR from NYC) from your health care provider or your county health department**
- **A blood test (titer) lab report that proves your child is immune to Hepatitis B, MMR, or Varicella. For Varicella (chickenpox), a note from your health care provider (MD, NP, PA) which says your child had the disease is also acceptable.**

Together We Build Excellence

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
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

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

☐ **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:**

☐ Additional Information Attached

Diagnoses/Problems (list) **ICD-10 Code***

*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.

Eastport/South Manor Central School District
149 Dayton Avenue
Manorville, New York 11949
(631) 801-3000 Fax (631) 874-6750

STANDARD DENTAL FORM

Student's Name _____ Date of Birth _____ Sex _____

School _____ Grade _____

REPORT OF DENTAL EXAMINATION

This is to certify that I have examined the teeth of the above-named student and I find:

- Oral hygiene is: _____ Good _____ Fair _____ Poor
- Number of teeth filled _____
- Number of teeth extracted _____
- All necessary dental work has been completed _____
- Treatment is in progress _____
- No dental work is necessary _____
- Is child under regular dental supervision? _____

REMARKS

Please elaborate on any of the above or make any recommendations that would assist the school in helping this child. _____

_____

_____

_____

_____

DATE OF EXAM _____

Dentist's Signature _____

Office Address _____

Date _____ **Phone Number** _____

Fax Number _____

PLEASE RETURN THIS COPY TO SCHOOL NURSE

Eastport/South Manor Central School District

149 Dayton Avenue • Manorville, New York 11949 • (631) 801-3000 • Fax (631) 874-6750

Eastport - South Manor
ESM
Central School District

Joseph Steimel
Superintendent of Schools

MEDICATION FORM FOR SCHOOL YEAR 2021-2022

Name: _____ **DOB:** _____ **Grade:** _____

Diagnosis: _____

Allergy: _____

Medication Name	Dose	Frequency	Route	Time	Possible Side Effects

MD Signature: _____ **Date:** _____

I request that my child, _____receive the medication/s as prescribed above by our licensed health care provider. The medication is to be furnished by me in the properly labeled, original container from the pharmacy, I understand that the school nurse, or other designated person, will administer the medication.

Parent/Guardian Signature: _____ **Date:** _____

For self-medication permission only: The above child has been instructed in the proper use of the above medications/procedures. I request that this child be able to carry the medication on his/her person, to keep it in his/her locker or PE locker as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency or use.

MD Signature: _____ **Date:** _____

Parent/Guardian Statement: I hereby agree not to hold the Eastport South Manor School District liable for any matter relating to the supervision of the self-medication procedure; it being recognized by me that it is not the responsibility of the school district to administer or supervise the administration of medication to students deemed self-manage.

Parent/Guardian Signature: _____ **Date:** _____

****HEALTH CARE PROVIDER STAMP NEEDS TO BE AFFIXED****

Eastport/South Manor Central School District

149 Dayton Ave • Manorville, New York 11949 • (631) 801-3000 • Fax (631) 874- 6750

Joseph Steimel
Superintendent of Schools

REQUIREMENTS FOR ADMINISTRATION OF MEDICATION FOR A CHILD DURING SCHOOL HOURS

If your child has to take a **prescription or over-the-counter medication** during the school day, the following procedure is necessary:

1. Medications may be administered in school only in compliance with New York State regulations.

2. Medications will be given **only** with a written order from a licensed health care professional and with written permission from the parent / guardian of the student. (This includes all medications such as prescription drugs, medicated cough drops, ear drops, ointments, Advil or Tylenol).

3. The physician's order can be on a prescription or they can complete the Administration of Medication in School form (can be downloaded from the schools website or picked up in the nurses office).
   This information must include:
   - Diagnosis or condition being treated
   - Dosage, frequency and route of medication
   - Information regarding the drug, such as it's use and possible side effects
   - Physician's name, address telephone number and license number

4. All medication MUST be provided by the parent. All medication must be in its **original container** (bearing a pharmacy label.) Pills placed in an envelope or separate container cannot be administered.

5. The medication will be kept in the School Nurse's office in a locked cabinet. ONLY self-directed students with SELF-CARRY forms are permitted to carry medications of any kind.

6. It is strongly recommended that all medications be given outside of school hours, and only administered during school hours when not doing so would be detrimental.

7. **Only medication delivered to the School Nurse by the parent/guardian will be accepted.**

8. **All medication must be picked up at the nurse's office prior to the last day of school or they will be discarded.**

9. **Orders must be dated from June 1, 2021, or after, to be valid for the 2021-2022 school year.**

Eastport-South Manor Central School District

149 Dayton Avenue • Manorville, New York 11949 • (631) 801-3000 • Fax (631) 874-6750 • www.esmonline.org

JOSEPH A. STEIMEL
Superintendent of Schools

ADAM FRANKEL
Assistant Superintendent for Curriculum and Instruction

TIM LAUBE
Assistant Superintendent for Business & Operations

LINDA ANNE WEISS
Assistant Superintendent for Personnel & Student Services

Dear Parent/Guardian:

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings are required and will be completed at school **if not documented by your private physician on your provided forms**. Screenings completed by private providers **must** contain a **numeric value** to be considered valid. (Those indicating normal, WNL, or pass are not acceptable):

Vision

- **Distance** and **near** acuity for all newly entering students and students in Pre-K or Kindergarten, Grades 1, 3, 5, 7, and 11.
- Color perception screening for all newly entering students.

Hearing

- **Hearing** screening for all newly entering students and students in Pre-K or Kindergarten, Grades 1, 3, 5, 7, and 11.

Scoliosis

- **Scoliosis** (spinal curvature) screening for all girls in grades 5 and 7, and boys in grade 9.

A letter will be sent home if your child needs follow-up with your health care provider. Please contact the school's Health Office if you have any questions or concerns.

Eastport/South Manor Central School District

149 Dayton Avenue • Manorville, New York 11949 • (631) 801-3000 • Fax (631) 874-6750

JOSEPH A. STEIMEL
Superintendent of Schools

Exclusion from BMI Reporting

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or "BMI". The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student's school health examination. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting to New York State Department of Health information about our students' weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report.

The information sent to the New York State Department of Health will help health officials develop programs that make it easier for children to be healthier.

If you do not wish to have your child's weight status group information included as part of the Health Department's survey this year, please download this form and print and sign your name below and **return it to the school nurse in your child's building**.

****

Please do not include my child's weight status information in the 2021-2022 School Survey.

_____ _____

Print Child's Name **Date**

_____ _____

Print Parent Name **Parent Signature**