

CITY SCHOOL DISTRICT OF ALBANY  
BUREAU OF HEALTH AND PHYSICAL EDUCATION

SCHOOL HEALTH SERVICES  
INFORMATION FOR PARENTS OR GUARDIANS

The following information pertains to New York State regulations and City School District of Albany policies governing School Health Services.

### IMMUNIZATION

Communicable disease control is a primary responsibility of school and public health authorities. Mandatory immunization is one aspect of a comprehensive communicable disease control program.

*New York State Public Health Law, Section 2164 mandates that schools not permit a child to be admitted unless the parent/guardian provides the school with a certificate of immunization or proof from a physician that the child is in the process of receiving the required immunizations.*

The required immunizations for school attendance are:

- 3 doses of diphtheria toxoid (usually administered as DPT, DTaP, or DPT/Hib)
- 3 doses of pertussis and tetanus vaccine (usually administered as DPT, DTaP, or DPT/Hib) for students born after January 1, 2005
- 1 booster containing diphtheria, tetanus, and acellular pertussis vaccine (Tdap) for children born on/after January 1, 1994 and entering sixth grade or a comparable special education program with an unassigned grade after September 1, 2007
- 3 doses of oral polio vaccine (OPV) or three doses of enhanced inactivated poliomyelitis vaccine (EIPV or more recently IPV\*). *\*Note: "IPV" administered in the USA after 1988 is presumed to be EIPV.*
- 2 doses of measles vaccine, the first administered no more than 4 days before the first birthday, and the second no less than 28 days after the first
- 1 dose of rubella vaccine administered no more than 4 days before the first birthday
- 1 dose of mumps vaccine administered no more than 4 days before the first birthday
- 3 doses of haemophilus influenzae type b conjugate vaccine if given before 15 months of age or 1 dose if administered on or after 15 months of age for students entering preschool
- 3 doses of Hepatitis B vaccine for all children born after January 1, 1993 (includes Head Start, nursery, daycare)
- 3 doses of Hepatitis B vaccine for students enrolled in grade 7 on or after September 1, 2000. Children 11-15 years old may receive 2 doses of adult Hepatitis B to fulfill this requirement
- 1 dose of Varicella vaccine for children born on or after January 1, 1998 and entering kindergarten
- 1 dose of Varicella vaccine for children born on or after January 1, 2000 before enrollment in any school
- 1 dose of Varicella vaccine for children born on or after January 1, 1994 who enroll/are enrolled in grade six or a comparable special education program with an unassigned grade in September 2005
- 1 dose of Varicella vaccine for students born on or after January 1, 1994, and who transfer from another state or country and enter grade six after January 1, 2005

All of the above immunizations must be documented by your physician or the Health Department where the child received the immunizations, or must be from an official copy of the immunization record from the child's previous school.

A student may be exempt from any or all immunizations if a physician licensed to practice medicine in New York State certifies that such immunization/s may be detrimental to the child's health. This exemption is applicable until such immunization is found no longer to be detrimental to the child's health. The physician's certificate of exemption must indicate the medical condition or reasons that the specified immunizations might be detrimental to the child's health and the length of time for which the exemption must be in effect.

No certificate of immunization shall be required as a prerequisite to attending school for children whose parents/guardians hold genuine and sincere religious beliefs that are contrary to the practice of immunization. Such parents/guardians shall submit a written statement that must provide the name, address and phone number of their religious leader or advisor and an explanation of the specific belief that is contrary to the practice of immunization.

### HEALTH APPRAISALS

Education Law (Section 903) and Regulations of the Commissioner of Education require physical examinations of children when they:

- Enter a school district for the first time
- Are in grades Pre-K or K, 2, 4, 7 and 10
- Participate in interscholastic sports
- Need working papers

- Are referred to the Committee on Special Education
- Require an appraisal deemed necessary by school authorities to determine an appropriate educational program for the individual

If a report of a child's examination is submitted from a primary health care provider, it must be signed by a physician, a nurse practitioner or physician's assistant working in collaboration with the physician. Submitted reports of examinations must describe the condition of the student when the examination was given and must state whether such student is in a fit condition of bodily health to permit his/her attendance.

**No student who is new to the District will be allowed to participate in physical education classes until a health appraisal is completed and the results of the appraisal are filed in the student's health folder.**

The physical appraisal must be no more than twelve months prior to the commencement of the school year in which the examination is required.

Students must have a physical prior to participation in interscholastic sports.

## MEDICATION

School personnel are often asked to give medicine to children during school hours. Many medicines can be taken effectively outside school hours. If your doctor feels it is necessary for medication to be administered in school, contact the School Health Office to obtain a "Medication Permission" form. To administer medication to students in school the following steps must be taken for both prescription and over the counter medications.

1. Submit a written order to administer medication in school from your child's physician. The pharmacy label does not constitute a written order and cannot be used in lieu of a written order from a licensed physician. Faxed orders from licensed physicians are acceptable. Verbal permissions from the physician to administer medication are not acceptable.
2. Submit your written request that medication be administered to your child in school as ordered by his/her physician.
3. Deliver your child's medication directly to the Health Office in the original, properly labeled container.

Medications should not be transported daily to and from school. Parents/guardians should ask the pharmacist for two containers, one to remain at home and one at school. Medications must not be transported to school by students on school buses. This presents a danger to all students. Students may not carry medication on their person during the school day.

## MEDICAL EXCUSE - PHYSICAL EDUCATION

It is the responsibility of the parent/guardian to keep the school informed of any health condition that would affect their child's safety, school performance, or toleration of physical activity. If for any reason a child is unable to participate in the physical education program, the parent/guardian must provide appropriate documentation from the attending physician indicating the problem, the specific limitations and the duration of those limitations. If a child is to be excused from the regular physical education program for more than two weeks, the parent/guardian must obtain information from the attending physician regarding the student's ability to participate in an adaptive physical education program.

## HEALTH PROBLEMS

It is the responsibility of the parent/guardian to inform the school of any contagious diseases or unusual health problems that the child may have. In this way the school can plan for the child's safety and special needs in order to maximize the child's educational experience.

## SCREENING

Vision screening is provided for new entrants and students in grades K-3, 5, 7, and 10. Hearing screening is provided for new entrants and students in grades K, 1, 3, 5, 7, and 10. Parents/Guardians will be notified **ONLY** if problems are identified.

## EMERGENCY CONTACT

In the event a child is sick or injured in school, it is essential that the school have telephone numbers where a parent or responsible adult can be contacted. If the emergency contacts should change during the school year, parents/guardians **MUST** notify the school immediately and provide accurate, working phone numbers where a responsible party may be reached.

## HEALTH NEEDS

The emotional as well as physical needs of each child are the concern of the School Health Services personnel. Parents/guardians should contact the School Nurse/Teacher with information regarding the health needs of their child and to obtain information regarding available community health services that could respond to the needs of the child or family.

CITY SCHOOL DISTRICT OF ALBANY  
BUREAU OF HEALTH AND PHYSICAL EDUCATION

HEALTH HISTORY AND REGISTRATION

\_\_\_\_\_ SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ GRADE ENTERING \_\_\_\_\_

The information you provide on this form will become part of your child's Permanent Health Record. To protect your child and to help the District to appropriately respond to the health needs of your child, please answer all questions on BOTH sides of the form.  
A certificate of immunization must be attached to this registration.

\_\_\_\_\_ Child's Name (Last, First) \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Child's Address (No. and Street - Apt. No. - Zip Code) \_\_\_\_\_ Telephone Number/s \_\_\_\_\_

\_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_

\_\_\_\_\_ Father's Home and Work Telephone Nos. \_\_\_\_\_ Mother's Home and Work Telephone Nos. \_\_\_\_\_

\_\_\_\_\_ Emergency Contact #1 (Name, Relationship and Telephone Nos.) \_\_\_\_\_

\_\_\_\_\_ Emergency Contact #2 (Name, Relationship and Telephone Nos.) \_\_\_\_\_

\_\_\_\_\_ School Last Attended \_\_\_\_\_ Albany Public Schools Attended \_\_\_\_\_

\_\_\_\_\_ Health Care Provider \_\_\_\_\_ Approximate Date of Last Physical Examination \_\_\_\_\_

\_\_\_\_\_ Dentist \_\_\_\_\_ Approximate Date of Last Dental Examination \_\_\_\_\_

BROTHERS AND SISTERS:

Name	Date of Birth	Grade/School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Note:** For the safety and wellbeing of your child, you must be accessible in the event of illness or injury. Notify the school immediately if any of the emergency numbers or contacts you provided above change. It is not in the best interest of an ill or injured child to be maintained indefinitely at school. Parents must pick up their child when the child is ill or injured. If parents are unable to do so, they must designate a responsible adult to pick up and attend to their child.

OVER →

If your child has had any of the following health problems or diseases, please check below and comment when necessary.

HEALTH HISTORY			COMMENT
			Please use this space to provide details for any condition/s checked.
Blood Disorders	<input type="checkbox"/>	Allergies	
Chicken Pox	<input type="checkbox"/>	Asthma	
Chronic Ear Infections	<input type="checkbox"/>	Birth Defects	
Hearing Loss	<input type="checkbox"/>	Bone/Joint Muscle Problems	
Hepatitis	<input type="checkbox"/>	Diabetes	
Mono	<input type="checkbox"/>	Heart Disease or Murmur	
Scarlet Fever/Strep	<input type="checkbox"/>	Lead Level Elevated	
Sickle Cell Disease	<input type="checkbox"/>	Operations/Hospitalizations	
Speech Problems	<input type="checkbox"/>	Seizure Disorders	
Tuberculosis	<input type="checkbox"/>	Serious Injuries	
Vision Problems	<input type="checkbox"/>	Other Health Issues	

Were there any complications during the pregnancy of this child? \_\_\_\_\_ If so, please describe. \_\_\_\_\_

What was the length of the pregnancy? \_\_\_\_\_ What was your child's birth weight? \_\_\_\_\_

Were there any complications during the birth of this child? \_\_\_\_\_ If so, please describe. \_\_\_\_\_

Does your child take any regular medications? If so, please list. \_\_\_\_\_

Does your child have any social or emotional problems that may impact his/her ability to learn and socialize in school? \_\_\_\_\_ If so, please explain. \_\_\_\_\_

**New York State Education Law requires all new entrants (including Pre-K and Kindergarten) and students in 1st, 3rd, 7th and 10th grades to have a physical exam. If a physical form is not returned to school before our school physicians come for physicals, your child will have a health appraisal in school.**

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

\_\_\_\_\_  
Date

CITY SCHOOL DISTRICT OF ALBANY  
BUREAU OF HEALTH AND PHYSICAL EDUCATION

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Your health care provider will require this form in order to share protected medical information with the City School District of Albany. Please complete this form, sign it, and give copies to your health care provider and the School Nurse/Teacher as soon as possible.

I authorize the disclosure of my child's protected health information as described below. I understand that this authorization is voluntary and made to confirm my direction.

Parent: \_\_\_\_\_ Child: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

Persons authorized to use or disclose information as specified below:

Health Care Provider	Address	Phone/Fax
		/
		/

Persons authorized to receive protected health information from the providers listed above:

School Personnel	Title	Address	Phone/Fax
			/
			/
			/
			/

Check below the information that may be disclosed:

- Health Appraisal
- Immunizations
- Recent Health History
- Medications
- Allergies
- Entire Record
- Lab Results: Type \_\_\_\_\_ Date \_\_\_\_\_
- X-Ray and Imaging Reports: Type \_\_\_\_\_ Date \_\_\_\_\_
- Consultation Reports: Consultant: \_\_\_\_\_  
Consultant \_\_\_\_\_
- Other: Specify \_\_\_\_\_
- Recent Discharge Summary

The protected information may be used, disclosed, or received for the following purposes (check all that apply):

- Medication administration
- Therapy prescriptions for PT/OT/ST
- Participation in physical education/athletics
- To develop care/therapy plans
- To design appropriate educational programs
- To share school observations regarding behavior
- To address the impact of medical conditions on school programming and/or attendance
- To assess the medical basis for transportation and/or home tutoring
- Other: \_\_\_\_\_

Please check one:

- This authorization is valid for the entire academic year 20\_\_ to 20\_\_.
- This authorization shall expire on \_\_\_/\_\_\_/\_\_\_

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my health care provider's office and to the school administrator.

I understand that the revocation of this authorization is not effective if the health care provider or the District has used the authorization for disclosure of protected health information prior to receiving my written revocation notice.

I understand that information disclosed as a result of this authorization may be disclosed by the person or organization to which it is sent. I understand that it may not be possible to ensure my right to the protection of the privacy of this information once disclosed.

I understand that my child's treatment is not dependent upon my agreement to release or withhold information.

\_\_\_\_\_  
Signature of Parent/Guardian or Student (Over 18)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**  
A copy of this authorization must be given to the parent/guardian or to the student over 18 years of age.

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

**IMMUNIZATIONS/SCREENING**

Immunizations given since last Health Appraisal:  None given today  Immunization record attached

	1st	2nd	3rd	4th	5th
DTaP					
IT				**	
OPV/IPV/EIPV					
TIB					
Step B					
Varicella					
MMR					
Other					

SICKLE CELL SCREEN		Date
Positive	Negative	
PPD		Date
Positive	Negative	
LEAD SCREEN		Date
Positive	Negative	

Flu Disease/Date:			
Vision—without glasses/contact lenses	R	L	
Vision—with glasses/contact lenses	R	L	
Vision—Near Point	R	L	
Hearing	R	L	

\*PLEASE PROVIDE MO/D/YR FOR ALL. \*\*If IPV  
 \*Required for entry to school in NYC; Requirements may vary by age/grade

Significant Medical/Surgical History  see attached \_\_\_\_\_

Allergies:  None  Food  Insect  Seasonal  Medication  LIFE THREATENING \_\_\_\_\_

PHYSICAL EXAM DATE \_\_\_\_\_  
 BP \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

Check here if entire exam normal

	Normal	Abnormal	Comments
Nutrition/Body Mass Index			Scale of 1-5: 1=Cachectic (BMI<17.5), 3=WHL (BMI 18.5-24.9), 5=Obese (BMI >29.9)
General Appearance			
Extremities			
Skin			
Head			
Eyes			
Ears			
Nose, Throat, Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen/Hernia			
Genitalia			Tanner - I. II. III. IV. V. <span style="float:right">Negative Positive</span>
Musculoskeletal			Scoliosis
Neurological			

**PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION**

- Physically qualified for all sports or full playground.
- Not qualified for full participation. May ONLY participate in the areas checked below.
  - Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water polo
  - Limited Contact/Endurance: baseball, cheerleading, cross-country, fencing, field events, floor hockey, gymnastics, handball, skiing, softball, swimming, track, volleyball
  - Non-Contact: archery, badminton, bowl, crew, dance, golf, jump rope, rifle team, table tennis, tennis, walking, weights
  - Knowledge based experience
- Physically qualified for employment OR specify accommodation \_\_\_\_\_
- Known or suspected disability \_\_\_\_\_
- Restrictions \_\_\_\_\_

PROVIDER'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_  
 PROVIDER'S NAME (STAMP) \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

CITY SCHOOL DISTRICT OF ALBANY  
BUREAU OF HEALTH AND PHYSICAL EDUCATION  
STUDENT HEALTH APPRAISAL

Parent/Guardian:

New York State Education Law requires students to have a physical examination when they:

- Enter a school district for the first time
- Are in pre-K or kindergarten, second, fourth, seventh, and tenth grades
- Participate in interscholastic sports
- Need working papers
- Are referred to the Committee on Special Education or are scheduled for a triennial review
- Require an appraisal deemed necessary by school authorities to determine an appropriate educational program

While these exams can be administered by the school physician, we urge you to use your child's health care provider. In this manner, a pattern of consistent, optimum health care can be established.

Each physical appraisal must describe the condition of the student when the examination was made, which may be no more than twelve months prior to the commencement of the school year in which the examination is required.

If the appraisal is for participation in interscholastic sports, it must be completed no more than 12 months prior to the first day of practice/tryouts for the selected sport.

Students who are new or returning to the City School District of Albany may not participate in the physical education program until a physical exam is performed and/or this completed form is returned to the school.

If this form is not completed and returned to school, or if students do not receive physicals from private physicians, health appraisals will be provided by the school physician during the course of the school year.

Contact the School Nurse/Teacher if you have any questions.

NOTE: If you have had your child's health care provider complete the front of this form, please return the form to the health office immediately.

Principal

School Nurse/Teacher

Telephone Number

Parent

Grade/Teacher

Please have the school physician examine my child.

Parent/Guardian (print)

Parent/Guardian's Signature

Date

NOTE: IF YOU DO NOT RETURN THIS PERMISSION OR THE COMPLETED FORM, YOUR CHILD WILL BE EXAMINED BY THE SCHOOL PHYSICIAN.