OHR REUVEN אור ראובן
YESHIVA KETANA

IMPORTANT MESSAGES FROM THE NURSE'S OFFICE

Enclosed you will find all relevant information needed for the 2017-2018 school year. Please read the information carefully**.** Some requirements were recently updated and some information pertains only to specified grades.

HEALTH HISTORY RECORD FORMS- **All NEW Students** need to fill out a Health History Form.

IMMUNIZATION REQUIREMENTS

Please check with your son's health care provider to ensure he has all the **newly required immunizations** to attend school.

PRE-1A • 6th • 7th and ALL NEW STUDENTS (regardless of their grade)

- Students entering **Pre-1A** are required to have had a 2nd MMR and a 2nd Varicella (chicken pox) Vaccine.
- Students entering **6th grade** are required to have had a 2nd Varicella (chicken pox) Vaccine and a Tdap booster. (The Tdap booster is required by their 11th birthday.)
- Students entering **7th grade** are required to have a Meningococcal Vaccine.
- **ALL NEW STUDENTS** are required to submit an up-to-date, complete immunization record that meets NYS Immunization Guidelines.

Documentation of these Vaccines must be submitted prior to the start of the school year.

HEALTH APPRAISAL/PHYSICAL EXAMS

NYS mandates Health Examinations for the following grades:

PRE-1A • 2nd • 4th • 7th and ALL NEW STUDENTS (regardless of their grade)

Please send in a current physical for your child. A physical form dated after 9/1/2016 will fulfill the requirement for this school year.

ALLERGIES & MEDICAL INFORMATION

If your son has an allergy (food, insect, latex, etc.) or medical issue, please contact the school nurse at nurse@darcheinoam.org and have the appropriate forms filled out and signed by you and your child's Doctor. This will enable the yeshiva to properly care for your child during the school day.

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MEDICATION

Medication cannot be administered without a signed authorization from you and your child's Healthcare Provider. This includes all over the counter medications, e.g. Tylenol, Motrin, Benadryl and Tums. You can find the "Authorization for Medication" form on the school website and in this packet. Completing this form before the start of school will prevent any inconveniences or delays if your son should need Tylenol, Motrin...during the school day.

Please return the completed documentation to the school by mail, fax (845-352-9593) or email (businessoffice@darcheinoam.org).

RAMAPO CENTRAL PHYSICAL FORM

(to be completed by private health care provider or school medical director)

Name: **Date of Birth:** / / **Gender:** ☐ M ☐ F

School: **Grade:** **Date of Exam:** / /

Current Diseases: ☐ Asthma ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Hypertension ☐ Hyperlipidemia ☐ Other:_____ (attach emergency care plans)

Significant Medical/Surgical Information:

Physical Examination: ☐ System Review and Exam entirely Normal

☐ Abnormalities: Specify:_____

Height: **Weight:**	**Scoliosis:** ☐ Negative ☐ Positive
BMI: ___ ___ . ____	**Degree of deviation:**
Weight status category (BMI percentile)	**Hearing:** R ____db sc L ____db sc
☐ < than 5th ☐ 5th - 49th ☐ 50th – 84th	**Vision:** R 20/___ L 20/___ distance ☐ with lenses
☐ 85th – 94th ☐ 95th – 98th ☐ > 99th	R 20/___ L 20/___ near ☐ with lenses
BP____/____ **HR** _____ **RR** _____	**Color Perception:** ☐ Pass ☐ Fail
Tanner Stage: I II III IV V	

Immunizations: ☐ Up to date, see attached form ☐ Delayed_____

Labs: U/A _____ **Other Significant:**_____

Tuberculosis : ☐ No risk factors, not indicated ☐ Mantoux result: ___ mm Date: ___/__/___

Medications: _____

Note: Separate Rx needed for all meds to be given in school, including OTC

Allergies: ☐ None ☐ Non Life-Threatening ☐ Life-Threatening

Type: ☐ Food ☐ Insect ☐ Latex ☐ Medication ☐ Seasonal/Environmental ☐ Other:_____

Specify allergen(s):_____

Specify Previous symptoms: _____ ☐ History of anaphylaxis; last occurrence:_____

Emergency Care Plan for anaphylaxis: ☐ Yes ☐ No

Recommendations or Restrictions for Participation in Physical Education/Sports/Work:

☐ Free from contagions and physically qualified for all activities (phys ed., athletics, playground, work, school)

☐ Recommendations/restrictions: _____

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ **Date:** _____

Provider Name: (please print) _____ **Phone #:** _____

Provider Address: _____ **Fax #:** _____

Return to School Nurse: Ramapo Central School District – Yeshiva Ketana Ohr Reuven/Yeshiva Darchei Noam
257 Grandview Ave.
Suffern, N.Y. 10901
Phone: 845-352-7100
Fax: 845-352-9593
EMAIL: businessoffice@darcheinoam.org

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Authorization for Medication Form

To Be Filled Out By Physician and Parent

Individual Orders for:
Name:_____
Date of Birth: _____
Weight: _____

The following Standard Over the Counter/PRN medications are available in the Nurse's Office and can be administered at the discretion of the RN (or school administrative staff in RN's absence), if authorized by the student's parent and health care provider.

MEDICATION	ROUTE	DOSE	TIMES TO BE ADMINISTERED	INDICATIONS	COMMENTS
Tylenol					
Motrin					
Benadryl					
Tums					

Student's Physician Name:_____
Address_____
Phone #_____ License #_____
****MD Signature_____ Date_____
****Parent's Signature_____ Date_____

Please complete one Health History Record for each **NEW** student.

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HEALTH HISTORY RECORD

STUDENT'S NAME_____ **DATE OF BIRTH**_____

ADDRESS_____ **GRADE**_____

HOME TELEPHONE _____ **STUDENT'S BIRTHPLACE**_____

FATHER'S NAME_____ **BIRTHPLACE**_____

MOTHER'S NAME_____ **BIRTHPLACE**_____

CHILD'S DOCTOR'S NAME_____**TELEPHONE**_____

CHILD'S DENTIST'S NAME _____**TELEPHONE**_____

ORTHODONTIS'S NAME _____**TELEPHONE**_____

Has pupil had any of the following illnesses? Please give year.

Chicken pox_____
Tuberculosis_____
Pneumonia_____
Bronchitis_____
Lyme Disease_____
Mononucleosis_____
Diabetes_____

Rheumatic Fever_____
Scarlet Fever_____
Seizure Disorder_____
Heart Disease_____
Migraine_____
Asthma_____

Other_____

ALLERGIES TO:

Medications_____
Seasonal _____
Food_____
_____

Is there any other phase of the pupil's health that the school should be aware? i.e. High fevers, serious illnesses heart murmurs, surgeries, serious injuries or any other medical problems that should concern the school._____

_____

_____

Has your child ever been hospitalized? _____**If yes, when and why**_____

Any history of Amblyopia (lazy eye) in the family? No___Yes___ **Relationship to child**_____
Has pupil had a vision exam with an eye doctor? No___Yes___ **Date**_____
Does pupil wear glasses? No___Yes___ **When was present lenses received?** ____
Has pupil seen an eye doctor for any other eye condition? No___Yes___ **Describe** _____
Does pupil have any speech problems? No___Yes___ **Has there been any speech therapy?** ____
Has pupil received any Dental Care? No___Yes___
Orthodontia (braces) No___Yes___

Additional information or comments: _____

_____

_____

Parent/guardian _____**Date**_____

Please submit by mail, fax (845-357-9593) or email (businessoffice@darcheinoam.org).