SEM BUFFALO SEMINARY EST. 1851
Buffalo Seminary Health Examination Form
205 Bidwell Parkway, Buffalo NY 14222 Phone: (716)885-6780 FAX: (716)885-6785

NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: Buffalo Seminary requires a physical exam annually for all students and annually for interscholastic sports.

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results:_____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ 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

Name:	DOB:

SCREENINGS

Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V ☐

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

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Buffalo Seminary Day Student Emergency Contact & Permissions Form 2019-2020

This form must be submitted each year. Please return Permissions and Health Appraisal forms by August 1, 2019. Forms are to be returned to the Main Office: Buffalo Seminary, 205 Bidwell Parkway, Buffalo, NY 14222 or fax (716)885-6785. If you have any questions please contact the Main Office at (716)885-6780.

Emergency Contact Information

Student Name:	Date of Birth:	Class of:
Parent/Guardian 1 Name:	Relationship:	
Phone number:		
Email:		
Address:		
Parent/Guardian 2 Name:	Relationship:	
Phone number:		
Email:		
Address:		

Permission for Emergency Medical Treatment:

In the event of an emergency requiring medical attention, I hereby authorize and consent to the designated responsible Buffalo Seminary representative in charge, present with my daughter, to act in accordance with his or her judgment to seek appropriate care for my daughter with a licensed physician, nurse or emergency personnel for treatment. This representative is absolved from any liability or financial responsibility in connection herewith.

Permission for Over-the-Counter (OTC) Medication Administration:
To receive stock OTC medication, a completed Buffalo Seminary Provider and Parent Permission to Administer Medication form must be on file with the Nurse.

Please indicate any allergies, medication allergies or special medical conditions and recommended treatment:

Parent/Guardian Name: Date:

Signature:

For Office Use Only

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Transportation Permissions:

As a part of daily activity at SEM, students will attend school sponsored field trips, outings, sporting events, club activities, service projects, cultural and social activities, etc. Transportation is arranged by Buffalo Seminary bus or authorized vehicle or faculty/staff member's personal vehicle. Please check all that apply:

☐ I give permission for my daughter to ride in Buffalo Seminary authorized vehicles to and/or from school-sponsored activities and events, class field trips, sporting events, clubs, service projects, etc.

☐ I give my daughter permission to drive her own vehicle to/from school-sponsored activities and events.

☐ I give my daughter permission to ride as a passenger in a student-driven vehicle to/from school-sponsored activities and events.

☐ I give my daughter permission to ride a bike to/from school-sponsored activities.

For more information regarding policies and procedures please see the Buffalo Seminary Student/Parent Handbook on the portal.

I understand the above permissions will be granted only in accordance with the rules and regulations of the school. I understand that there are normal risks of travel and participation in trips and I hereby assume the risk of any injury to my child however caused and whether by negligence or otherwise.

Student Name:

Parent/Guardian name:	Date:
Signature:	Phone Number:

Photo and Video Usage Policy:

1. We will use only images (video and still photography) that reflect positively on the student and the school.

2. We may identify an individual student with her picture if she has earned a specific honor (e.g., top scorer in an athletic game, National Honor Society inductee, community award winner, etc.) and/or is identified publically elsewhere, such as The Buffalo News or Buffalo Business First.

Parent/Guardian Agreement to the Use of Photos and Videos of Students:
Buffalo Seminary reserves the right to use video footage and/or photographs of my daughter. The video footage and/or photographs will be the property of the school. Rights to these materials are waived, including the right to inspect and/or approve copy that may be used in conjunction with uses to which they may be applied. The pictures and/or video footage may be used as Buffalo Seminary sees fit for the production of educational or promotional materials and any other lawful purpose.

Media Opt Out:
☐ I do not give Buffalo Seminary the right to use video footage and/or photographs of my daughter.

Student Name:	Grade:
Parent/Guardian Name:	Date:
Signature:	

Please address any questions to Erin Kelly, Director of Communications, at ekelly@buffaloseminary.org.

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Buffalo Seminary Provider and Parent Permission to Administer Medication

This form must be submitted each year. Please return completed form by August 1, 2019. Forms are to be returned to the Main Office: Buffalo Seminary, 205 Bidwell Parkway, Buffalo, NY 14222 or fax (716)885-6785.
If you have any questions please contact the Main Office at (716)885-6780.

All students must have patient specific orders from their provider for any prescription and over the counter (OTC) medication along with written parent/guardian consent for such medications to be administered to, or taken by their child, including school stock OTC. Parent/guardian consent must specify permitting administration of stock medication. These medications include, pain reliever, fever reducer, anti-inflammatory, antihistamine, decongestant, antacid, topical applications, cough drops, and sunscreen.

To be completed by parent or guardian:

I authorize the school health staff to give my child the following prescription or OTC medication as prescribed by our licensed health care provider. After the school nurse determines that my child can take their own medications, other trained staff may assist my child to take their own medications. Prescription medication will be provided by me in the properly labeled original container from the pharmacy. OTC may be given from health office stock supplies ONLY if written authorization is given by the student's parent/guardian or health care provider.

Student Name:	Date of Birth:	Class of:
Parent/Guardian Name:	Relationship:	
Phone where we can reach you:	Email:	
Signature:	Date:	

To be completed by licensed health care provider – VALID FOR 1 YEAR

Diagnosis:
Medication(s), dosage, frequency, route, and times, to be taken during the school day:

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

The school nurse has my permission to administer the following OTC medication to my patient (provide dosage):

_____Acetaminophen	_____antacid	_____topical
_____Ibuprofen	_____cough drops	
_____Diphenhydramine	_____sunscreen	

☐ Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)
NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and complete the attestation to request this option.

Name/Title of Prescriber (Please Print):	
Prescriber's Signature:	Date:
Phone:	
Address:	

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Provider Attestation and Parent Permissions for Independent Medication Carry and Use

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A provider order and parent/guardian permission are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: Date of Birth:

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with: _____

☐ Allergy and requires Epinephrine Auto-injector

☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication

☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies

☐ _____ which requires rapid administration of _____

(State Diagnosis) (Medication Name)

Name/Title of Prescriber (Please Print):

Prescriber's Signature: Date:

Phone:

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Name:

Signature: Date: