FROM THE NURSE

Physicals

All students need to provide the nurse with a copy of their most recent physical examination and immunizations. Even though you go to the doctor every year most doctors don't give you a copy of the shots and check-up unless you request it. This information is required by the Department of Health to be in your child's health record. Students who want to participate in any type of sport at Birchwood are required to have a Health Record. Most students coming from the elementary school only have their kindergarten physicals on file from initial registration. Please send a fax or bring in your child's physical for the start of school in September.

Dental Cards

Documentation from the dentist is also required for your child's health record.

Medication

If for any reason your child will need to take any type of medication the doctor needs to fill out a medication authorization form. This is required for all medication, even Tylenol.

Epi-Pens and Inhalers

If your child has an allergy that requires and EPI-PEN, we must have an EPI-PEN at school. Children with asthma who need inhalers need to have them in school with the doctors written orders.

Peanut Allergies:

We have students in the school who have severe peanut allergies. We have a peanut free table as well as a NUT table in the cafeteria. We would like to suggest not packing anything that contains nuts in your child's lunch. If they do have anything with NUTS in their lunch they need to sit at the NUT table and make sure they wash their hands after they eat. This is very important and needs to be followed to insure the safety of our children.

Thank You!
Mrs. Kelly Nesbitt, M .Ed, R.N., CSNT

NORTH PROVIDENCE SCHOOL DEPARTMENT
ANNUAL HEALTH HISTORY UP-DATE

PLEASE NOTE: The information on this form will be used to up-date your child's health records.

Please complete this form and return to Certified School Nurse Teacher as soon as possible. Thank you.

Student: _____

Date of Birth:_____ Grade:_____ Teacher:_____

Pediatrician: _____ Phone:_____

Dentist: _____ Phone:_____

HEALTH INFORMATION

If your child has a pre-existing diagnosis or condition, please indicate: _____

List allergies: _____
If allergic to bee stings and/or food do they require an EpiPen? Yes No

List surgeries:_____

List serious illnesses or injuries: _____

List any health conditions that CSNT needs to be aware of: _____

_____

Please check if any of the following health problems exist:

___Asthma
___Bone or Joint Disease
___Diabetes
___Seizures
___Heart Problems
___Kidney Problems
___Throat Infections (frequent)
___Eczema
___Dental Problems
___Ear Infections/Tubes: Left Right Both
___Menstrual Problems
___Headaches/Migraines
___Vision Problems (does she/he require glasses/contact lenses? Yes No)

If yes to any of the above please explain: _____

Please list medications your child is currently taking and the reason why:

Medication:_____ Reason:_____

Medication:_____ Reason:_____

Signature Parent/Guardian:_____ Date:_____

******Please note the following information regarding health screenings in the school******

Vision- Children are screened upon entry and in 1st, 2nd, 3rd, 4th, 5th,7th and 9th grades;

Hearing-Pre-K, K, 1st, 2nd, and 3rd and any new students without prior hearing screening

Dental-all students in pre-K-5th and grade 7 Scoliosis Grades 6, 7, and 8

These screenings are administered by trained personnel. If you elect not to have any of these screenings done in school, satisfactory evidence must be provided to the school nurse stating that the same exam/test has been completed within the preceding 6 months by the students' health care provider. Please submit this documentation by October 1st to the school nurse.

***SEE BACK SIDE >>

BIRCHWOOD MIDDLE SCHOOL

10 Birchwood Drive, North Providence, Rhode Island 02904, (401) 233-1120 FAX (401) 353-6903

Dear Parent of a North Providence Student Athlete:

Enclosed is a Report of Physical Examination form providing medical clearance by your child's doctor for your child participates in any of the North Providence School Department's athletic programs. In keeping with nationally recommended medical standards designed to insure a child's health and safety, the school department strongly recommends that every child annually visit his/her own doctor for a general medical history review, a medical examination and any and all prescribed screening tests/immunizations.

Please present this form to your child's doctor at the time of his/her annual visit. **You should keep a copy of your records as the nurse cannot make copies for the athletic director.***

The physical is valid for one year from the date of the exam.

Cordially,

Kelly Nesbitt RN, M.Ed.
School Nurse/Teacher

*Students entering 7th grade are required to present two separate physical forms, one for the nurse and one for the athletic director.

NORTH PROVIDENCE SCHOOL DEPARTMENT

HEALTH OFFICE
MEDICATION AUTHORIZATION SHEET

Student: _____

Date of Birth:_____ Grade:_____ Teacher:_____

The following medication will be dispensed by the Certified School Nurse Teacher as deemed necessary. **Per policy, these medications are provided as a "one time" dose.**

- Tylenol (Acetaminophen or equivalent)
- Motrin (Ibuprofen or equivalent)
- Tums 1 – 2 tablets

If your child continues to require these medications on a routine basis, it will be necessary to provide a completed North Providence Medication Authorization and Consent Form signed by the student's physician. These medications must be transported to school by an adult in an original container labeled with the student's name.

PARENT/GUARDIAN AUTHORIZATION:
I have read and understand the North Providence School Department Medication Policy. I request that my child be given the medication as described above in accordance with said policy. I understand that the school is rendering a service, and retain full responsibility for any effects resulting from the administration of said medication.

Please note: Your child will not receive any of the above medications until the Health Office Medication and Authorization Sheet is on file.

Please list any allergies: _____

List any health conditions that CSNT needs to be aware of: _____

_____

Signature Parent/Guardian:_____ Date:_____

School Name & Address:

Health Care Provider Name and Address:

Phone:

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap/Td ≥ 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

Medical Exemption:

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height _____ Weight_____ BP_____

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

1. ASTHMA: No ☐ Yes ☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
2. ALLERGIES: No ☐ Yes ☐ (Please explain) _____EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐
   If student has a severe allergy (food, insect, other) complete a *Food Allergy& Anaphylaxis Emergency Care Plan* (www.foodallergy.org/document.doc?id=234)
3. DIABETES: No ☐ Yes ☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
4. OTHER: _____

Treatment Plan: _____

RESTRICTIONS: Can participate in physical education/sports: Fully☐ With limitation ☐ _____

MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

LEAD SCREENING (Required for children < 6 years old)
Student is in compliance with lead screening requirements:
Yes ☐ No ☐

SCOLIOSIS SCREENING
Yes ☐ No ☐

VISION SCREENING (Children entering Kindergarten)
☐Passed Screening ☐Screened & referred for comprehensive exam
☐Referred for comprehensive exam, but not screened

TUBERCULOSIS (If required by school district)
Date of TB test:

Screening / Referral Date:

Comprehensive Exam Date:

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

TOWN OF NORTH PROVIDENCE SCHOOL DEPARTMENT
MEDICATION AUTHORIZATION AND CONSENT FORM

A Certified School Nurse/Teacher has permission to administer the medication prescribed below to my child.

Student Name: _____ Date of Birth: _____ Grade: _____ Room: _____

The school physician and/or nurse teacher has permission to discuss medical issues with the prescriptive issuing physician/dentist.

____Yes ___ No I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my son's/ daughter's health and safety.

_____	_____	_____	_____
Parent/Guardian Signature	*Date*	*Home Phone*	*Work Phone*

Physician/Dentist Medication Information
(The following is to be completed by the physician/dentist)

Diagnosis for which medication is given: _____

Name of medication: _____

Form of Medication *(e.g. liquid, tabs, etc.)* _____ Dosage _____

Time to be given: _____ If medicine is to be given "when needed", describe indications:

_____

Length of time medication is to be taken: _____ Expiration Date: _____

Significant side effects: _____

May the student self-administer and carry his/her inhaler : __Yes __No

If the child is on a field trip, may medication be omitted: __Yes __No

Hospital child should be transported in case of emergency: _____

Other information: _____

_____	_____	_____	_____
Physician/Dentist's Signature	*License No.*	*Date*	*Phone No.*

Please note: Medicine will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.