ST. LUKE'S SCHOOL ♦ 487 HUDSON STREET ♦ NY, NY 10014 ♦ PHONE (212) 924-5960 ♦ FAX (212) 924 1352

ANNUAL HEALTH FORM FOR MEDICAL PROVIDER 2015-2016

**** Medical Provider may provide their own form, but MUST SIGN THIS FORM and return with their form attached**

Last Name _____ First Name _____ DOB_____ **DATE OF EXAM _____**

Height _____ Weight _____lbs BMI_____% Pulse _____ Resp _____ BP ____ /_____

IMMUNIZATION RECORD: Please attach up-to-date official record of immunizations.

SCREENINGS:

Date	Screening	Result/Value
	VISION	R: L:
	HEARING	R: L:
	Blood Lead	µg/dL
	PPD Mantoux	mm
	Chest X-Ray	☐ NL ☐ Abn F/U:

Hx Chickenpox Disease: YES NO

Additional Screenings/Health Information :

ASTHMA:

Does the child have a history of asthma? ☐ NO ☐ YES **(please complete the Asthma/Allergy Plan of Care Form)**

ALLERGY:

Does the child have any allergies? ☐ NO ☐ YES **(please complete the Asthma/Allergy Plan of Care Form)**

PARTICIPATION:

The child is free from contagions and is physically qualified for all physical education, sports, playground, and school activities: ☐ NO ☐ YES

If no, please explain below:

MEDICATIONS:

Does the child require any medication to be given in school? ☐ NO ☐ YES

If yes, please list medication and instructions below:

OTC MEDICATION AUTHORIZATION/CONSENT:

School Nurse may administer medications below with provider and parent consent. The dose/interval is based on weight per package instructions. Provider provides that the student may be directed with supervision and support of trained staff, for trips when RN is unavailable. St. Luke's School will act based on the information provided here. Consent covers the school term or 12 months from date. ***Signatures of medical provider and parent are required for medication administration.*** **Medical Providers: please check off No OTC meds or specific medicines, if they are not to be given otherwise, your signature will be consent to give OTC meds.**

- ☐ NO OTC MEDS TO BE GIVEN
- ☐ Ibuprofen (Motrin/Advil)
- ☐ Acetaminophen (Tylenol)
- ☐ Tums
- ☐ Cetirizine HCl (Zyrtec)
- ☐ Loratidine (Claritin)
- ☐ Benadryl PO
- ☐ Napcon A eyedrops (allergy)
- ☐ Topical Benadryl
- ☐ Cortisone 1% cream
- ☐ Witch hazel topical
- ☐ Lubricant eyedrops (saline)

Physician Name:_____ **OFFICE STAMP REQUIRED:**

Phone: _____ Fax:_____

Signature:_____ Date:_____

PLEASE RETURN BEFORE JUNE 15 ♦ ATTN: School Nurse ♦ Fax: 212.924.1352 ♦ nurse@stlukeschool.org

ASTHMA/ALLERGY PLAN OF CARE

****The following constitutes plan of care and medical orders for administration of medication by the School Nurse (RN)**

Student Name_____ Date of Birth_____ Age_____ Weight_____lbs

Parent Contact (to be filled out by School RN)

Plan of Care (to be filled out by the Medical Provider)

ALLERGY PLAN

Allergens: ☐ Peanut ☐ Tree Nuts ☐ Soy ☐ Dairy ☐ Egg ☐ Shellfish ☐ Wheat ☐ Other_____
Indicate severity of each allergen: _____
_____

Has allergy been CONFIRMED by testing? ☐ NO ☐ YES Age_____
Has the child had an anaphylactic reaction? ☐ NO ☐ YES Age_____

TREATMENT

Epinephrine: IM ☐ 0.3mg Adult ☐ 0.15mg Junior Brand_____
☐ Immediately after: ☐ Known ingestion ☐ Suspected ingestion ☐ Inhalation ☐ Touch
☐ Student may carry and self administer Epinephrine (only applies to students in Grade 5 and above), when specific symptoms of anaphylaxis develops (any 2 systems or airway/CVS): ☐ NO ☐ YES

Antihistamine:
☐ Benadryl_____ mg PO ☐ Cetirizine HCL_____mg PO ☐ None

**Antihistamine will not be delegated to staff for administration as part of the Allergy Plan of Care. School staff will be trained for recognition of severe allergic reactions and only administration of epinephrine for anaphylaxis when RN is unavailable and on off campus trips. (NYC DOE Reg.A-715)
**Initiation of 911 REQUIRED in the event of administration of Epinephrine for anaphylaxis.

ASTHMA PLAN

Classification: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
Peak Flow: Personal Best (PB)_____ Green_____ Yellow_____ Red_____ (<50% of PB)
Triggers: ☐ Dust ☐ URI ☐ Mold/Mildew ☐ Animal:_____ ☐ Other:_____
☐ Exercise: pre-medicate prior to exercise with_____
☐ Other:_____
Medication for School Administration:
_____Dose/Route_____ Interval_____ ☐ PRN

_____Dose/Route_____ Interval_____ ☐ PRN

Student may carry and self-administer medication: ☐ NO ☐ YES
List Medications taken at home on regular basis for Asthma:_____

*****Albuterol Solution 2.5 mg/3ml/0.083% via Nebulizer/ q 4-6 hours.*** *Health Office stock administered when MDI is unavailable. (NYSED 8/23/11)*
******A spacer is required for each MDI provided for school administration.***
***Student will be directed with support/supervision of trained staff for off-campus trips when RN is not present.*

Medical Provider's Name: _____ Signature: _____ Date: _____

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