

THE BROWNING SCHOOL

From the Nurse's Office



52 East 62nd Street

New York, New York 10065

212 838 6280 EXT. 149

www.browning.edu

April 16, 2015

Dear Browning Parents:

Enclosed is the health form for the 2015-2016 academic years. The form must be completed and returned to the Health Office by **August 15, 2015**.

As you are aware, it is a school requirement that a yearly physical examination report be kept on file in the health office. **Without properly completed health forms on file, your son will be unable to begin school in september.**

In addition, a health directive has come from the NYC Department of Health and Mental Hygiene. All students will be **required** to have Hepatitis B vaccine. One dose of Varicella vaccine is also required for all children through and including Form III. Tdap is required for all children born on or after January 1, 1994 and those entering 6th Grade and above.

Please return the completed form to the attention of Maureen Linehan, RN, School Nurse. **Before returning the form, please make a copy for your file.** Thank you for your cooperation in this important matter.

Required form for returning students is:

- 1. Family Information Sheet And Physical Examination Form.**
- 2. Complete Immunization History.**

Sincerely yours,

Maureen Linehan, RN, BSN, NCSN
School Nurse

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HEALTH FORM

September 2015 – June 2016

GRADE _____

STUDENT'S NAME _____

BIRTH DATE _____

PARENT NAME (PRIMARY CONTACT) _____

HOME ADDRESS _____

TEL. NO. _____

BUSINESS _____

TEL. NO. _____

CELL NO. _____

PARENT NAME _____

TEL. NO. _____

HOME ADDRESS _____

TEL. NO. _____

BUSINESS _____

TEL. NO. _____

CELL NO. _____

CARETAKER NAME _____

CELL NO. _____

PERSONS TO CONTACT IF UNABLE TO REACH PARENTS

TEL. NO. _____

TEL. NO. _____

I give my permission for the school nurse to administer first-aid if such is needed. In the event that I cannot be reached, and emergency hospital care / treatment is needed, I give permission for my child to be taken to the nearest hospital and given the necessary emergency care.

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

The School Nurse May Administer The Following Medications:

___ TYLENOL ___ ADVIL ___ SUDAFED ___ BENADRYL ___ ANTACID ___ ROBITUSSIN ___ CLARITIN

OTHER* _____ (NAME AND DOSAGE)

ASTHMA MEDICATION* _____

PEAK FLOW _____

*Please be advised that any prescription medication must be in a labeled medication bottle from the pharmacy and kept in the Nurse's office. Any maintenance medication must be accompanied by a Doctor's order.

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

Physical Examination *(To Be Completed Each Year**)*

HEIGHT _____ WEIGHT _____ BMI _____

BLOOD PRESSURE _____ PULSE _____

LAST DENTAL EXAM _____

VISION: RIGHT _____ LEFT _____

HEARING: TYPE OF TEST _____ RIGHT _____ LEFT _____

ENT _____

CARDIOVASCULAR _____

URINALYSIS _____

ABDOMEN _____

HEMOGLOBIN/HEMATOCRIT _____

GENITALIA _____

EXTREMITIES _____

MUSCULO-SKELETAL _____

SCOLIOSIS CHECK _____

SKIN _____

MAY THE STUDENT PARTICIPATE IN ALL PHYSICAL ACTIVITY? _____

NEUROLOGICAL _____

EMOTIONAL _____

DENTAL _____

NUTRITIONAL _____

PAST ILLNESSES, INCLUDING CONTAGIOUS DISEASES _____

OPERATIONS _____

SIGNIFICANT FAMILY HISTORY _____

SIGNIFICANT CHRONIC PROBLEMS _____

MAINTENANCE MEDICATION _____

IMMUNIZATIONS DURING THE PAST YEAR _____

ALLERGIES _____

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S STAMP _____ TELEPHONE _____

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STUDENT'S NAME

DATE OF BIRTH

STUDENT'S GRADE

PLEASE INCLUDE **DAY, MONTH AND YEAR** OF EACH IMMUNIZATION RECORD

IMMUNIZATION HISTORY

	1ST	2nd	3RD	4TH	5TH
DTP					
DT/DTaP					
Tdap					
Hib					
OPV/IPV					
Hep B					
MMR					
VARICELLA					
MANTOUX					
Other/Specify					

PHYSICIAN'S SIGNATURE _____

DATE _____

PHYSICIAN'S STAMP _____

TELEPHONE _____

FULL COMPLIANCE

2014–15 School Year

New York State Requirements for School Entrance/Attendance¹

NOTES: The number of required vaccine doses depends on the schedule recommended by the Advisory Committee for Immunization Practices (ACIP).

This schedule reflects the number of doses required for Pre-K through grade 12. Intervals between doses of vaccine should be in accordance with the ACIP recommended immunization schedule for persons 0 through 18 years of age. See footnotes for specific information for each vaccine.

FULL COMPLIANCE 2014					
VACCINES	PRE-KINDERGARTEN (Day Care, Head Start, Nursery or Pre-K)	KINDERGARTEN	GRADES 1 through 5	GRADE 6	GRADES 7 through 12
Diphtheria and Tetanus toxoid-containing vaccine DTaP/DPT/Tdap	4 doses	4 to 5 doses If the fourth dose of DTaP was administered at age 4 or older, the fifth (booster) dose is not necessary.	4 to 5 doses If the fourth dose of DTaP was administered at age 4 or older, the fifth (booster) dose is not necessary.	3 doses	3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)	Not applicable	Not applicable	Not applicable	1 dose	1 dose
Polio (IPV/OPV)	3 doses	3 to 5 doses If 4 or more doses were administered before age 4 years, an additional dose should be received on or after age 4 years. For children 4 years of age or older who have previously received less than 3 doses, a total of 3 doses are required. If both OPV and IPV were administered as part of a series, a total of 4 doses should be received, regardless of the child's current age.	3 doses	3 to 5 doses For children 4 years of age or older who have previously received less than 3 doses, a total of 3 doses are required. If both OPV and IPV were administered as part of a series, a total of 4 doses should be received, regardless of the child's current age.	3 doses
Measles, Mumps and Rubella (MMR)	1 dose	1 dose	2 doses 2 doses required by age 7	2 doses	2 doses
Hepatitis B	3 doses	3 doses	3 doses	3 doses	3 doses
Varicella (Chickenpox)	1 dose	2 doses	1 dose	2 doses	1 dose
Haemophilus Influenza type b (Hib)	1 to 4 doses Number of doses depends on the child's age at the first dose; if you have questions, please consult with your physician.	Not applicable	Not applicable	Not applicable	Not applicable
Pneumococcal Conjugate Vaccine (PCV)	1 to 4 doses Number of doses depends on the child's age at the first dose; if you have questions, please consult with your physician.	Not applicable	Not applicable	Not applicable	Not applicable
Influenza	1 dose All children 6 months through 59 months of age enrolled in NYC Article 47 & 43 regulated pre-kindergarten programs (Day Care, Head Start, Nursery, or Pre-K) must receive one dose of influenza vaccine between July 1st and December 31st of each year. Some children may need 2 doses of influenza vaccine, depending on their prior vaccination history.	Not applicable	Not applicable	Not applicable	Not applicable

Note to Parents: The above schedule is the requirement for students who begin receiving their vaccines in infancy. There are different requirements for students who begin their vaccinations at a later age. If you have questions, please consult with your physician.

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Footnotes reflect updates as of April 2014. Please refer to <http://www.health.ny.gov/prevention/immunization/schools/> for updated information and Frequently Asked Questions (FAQs).

For further information contact:

New York State Department of Health, Bureau of Immunization, Room 649, Corning Tower ESP, Albany, NY 12237, (518) 473-4437.

New York City Department of Health and Mental Hygiene, Program Support Unit, Bureau of Immunization, 42-09 28th Street, 5th Floor, Long Island City, NY 11101, (347) 396-2433.

Office of School Health Citywide Contact Number (all Districts)

(347) 396-4597 • (347) 396-4503



SEPTEMBER 2014

MEDICAL REQUIREMENTS FOR NEW SCHOOL ENTRANTS

(PUBLIC, PRIVATE, PAROCHIAL, DAY CARE CENTERS AND SCHOOLS)

ALL STUDENTS ENTERING A NEW YORK CITY SCHOOL FOR THE FIRST TIME MUST HAVE A COMPLETE PHYSICAL EXAMINATION AND ALL REQUIRED IMMUNIZATIONS

The comprehensive medical examination must be documented on a Child Adolescent Health Examination Form (CH205) and include the following:

Weight	Height	Blood Pressure	Body Mass Index	Vision Screening
Hearing Screening	Dental Screening	Medical History	Developmental Assessment	Nutritional Evaluation

The CH-205 examination must be performed on or after April 1st of the year of school entry. Examinations performed prior to April 1st of the entry year will not be accepted. Fillable CH-205 forms that include the student's pre-populated vaccination histories are available through the New York City Immunization Registry (CIR). Students continuing on to Kindergarten from Pre-Kindergarten must submit a new CH-205.

Required Screening for Day Care Only	
Screening	Required Information
Anemia Screening	Hematocrit and Hemoglobin
Lead Screening, Assessment & Testing	<ul style="list-style-type: none"> All children under 6 years must be assessed annually for lead exposure. Blood lead tests are required for children at ages 1 and 2 years AND other children up to age 6 years at risk of exposure OR with no lead test previously documented. For more information, call the Lead Poisoning Prevention Program @ 311.

IMMUNIZATION REQUIREMENTS 2014–15

The following immunization requirements are mandated by law for all students between the ages of two months and eighteen years. Children must be excluded from school if they do not meet these requirements.

A child's immunization history must include all of the following vaccines to be considered fully immunized. Their immunization record should be evaluated according to the grade they are attending this school year.

PROVISIONAL REQUIREMENTS

New students may enter school provisionally with documentation of at least this initial series of immunizations. Once admitted provisionally, subsequent vaccines must be administered in accordance with the Advisory Committee for Immunization Practices (ACIP) 'catch up' schedule for the child to be considered 'in process' and remain in school (refer to <http://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html> for schedule). Alternative schedules are not acceptable. Students must complete the entire series to comply with the law. Students who have not been immunized within the provisional period must be issued exclusion letters and excluded from school until they comply with the requirements.

<u>DAY CARE/PRE-KINDERGARTEN</u>	<u>NO. OF DOSES</u>
DTaP (diphtheria-tetanus-acellular pertussis) OR DTP (diphtheria-tetanus-pertussis)	1
IPV (inactivated poliovirus) or OPV (oral poliovirus)	1
MMR (measles-mumps-rubella)	1
On or after the 1st birthday.	
Hib (<i>Haemophilus influenzae</i> type b)	1
Hepatitis B	1
Varicella	1
On or after the 1st birthday.	
Pneumococcal conjugate (PCV)	1
Influenza	1
Depending on their influenza vaccination history, some children may need 2 doses of influenza vaccine.	

<u>KINDERGARTEN/GRADES 1–12</u>	<u>NO. OF DOSES</u>
DTaP, DTP, DT, Td (tetanus-diphtheria) OR Tdap (tetanus-diphtheria-acellular pertussis)	1
Vaccine type as appropriate for age.	
Tdap	1
IPV or OPV	1
MMR	1
On or after the 1st birthday.	
Hepatitis B	1
Varicella	1
On or after the 1st birthday.	