ST. MARY OUR MOTHER SCHOOL

Dear Parents:

Welcome to St. Mary Our Mother School.

The following is important information regarding the school health services program.

MANDATED SCREENINGS

1. Height, Weight & Blood Pressure	K, 1, 3, 5 & New Students
2. Distance Vision:	K, 1, 2, 3, 5 & New students
3. Hearing screening:	K, 1, 2, 3, 5 & New students
4. Scoliosis screening:	Grades 5, 6
5. Near Vision, Color and plus Lens:	K & New Students

MANDATED HEALTH APPRAISALS

1. Pupil's at grade levels **PK, K, 1, 3, 5, 7, 9, 11 and New Entering Students** (A health appraisal is acceptable if it has been done **not more than twelve months prior to the first day of the school year** in which the exam is required. For the 2023-2024 school year, a health appraisal dated 9/3/22 or after will qualify.) Out-of-state physicals can no longer be accepted.
2. All **new entrants**
3. Health appraisals may be done by your family physician. Please ask your Doctor to complete an exam form and return that form to school within 30 days of entrance.
   We also have exam forms for your convenience.
4. If no health appraisal is filed an examination will be scheduled with the school physician.

MD PERMISSION/ MEDICATION POLICY IN SCHOOL

1. Medication will be given **ONLY** by **physician order**.
2. The order **MUST** also have a **parents' signature** on the form.
3. The parents are requested to bring the medication to school and physician order to the Nurse's office or the main office.
4. The **original prescription bottle** must be brought to the Nurse's office with the proper **label: child's name and medication name on the bottle with the original pharmacy bottle label.**
5. This also applies to over the counter medications such as ointments, cough Drops etc. (**ask Pharmacy to label a bottle for medications to come to school**).

If you have any questions, please call us at 607-739-9157.

ST. MARY OUR MOTHER SCHOOL
STUDENT MEDICAL HISTORY

Student Name_____ DOB _____ Entering grade_____
Please provide:
Physician's Name_____ Physician's Phone _____
Dentist's Name_____ Eye Specialist _____
Preferred hospital_____

Please indicate below any difficulties during pregnancy, labor, delivery, or shortly after birth.

Were developmental milestones, such as walking, talking, toilet training, etc. considered within normal limits?
Yes_____ No_____ If no, please explain_____
_____
_____

Is there any history of the following: (Yes or No)

1. Serious illness _____
2. Hospitalization _____
3. Accident or broken bones _____
4. Seizures, if yes, date of last seizure _____
5. Convulsions, kidney disease _____
6. Head injury _____
7. Vision or hearing problems _____

Check if child has had:

Epilepsy	_____	Diabetes	_____
Rheumatic Fever	_____	Asthma	_____
Chickenpox	_____	Heart Disease/Murmur	_____

Has your child ever had any serious accidents, operations or hospitalizations? (Specify)
_____
Allergies (Specify) _____
_____

Does your child have a history of frequent ear infections? _____

Other medical conditions? (Specify) _____

When was the child's last complete physical? _____
Any recommendations from the physician?
_____

Is the child presently on any medication during school hours: If so, what? _____
_____
(If yes, A medication order form must be completed and signed by Doctor and parent/guardian)

Has the child been on medication in the past? If so, what? _____

Does your child need/use glasses? Yes_____ No _____ Contact lenses? Yes _____No _____

Does your child have dental braces? _____ If so, name of orthodontist? _____