SOUTH SENECA CENTRAL SCHOOL
Middle-High School
Telephone Number 607-869-9636 7263 South Main Street, Ovid NY 14521 **Fax Number** 607-869-9553

Dena Ganoung, RN, School Nurse
dganoung@southseneca.org

August 2017

Dear Parents and Students,

I hope you all had a healthy and happy summer! I am looking forward to the 2017-18 school year, and seeing you all again. Please take time to fill in and return the enclosed forms. Please remember to notify the school if your phone number or address changes throughout the school year.

If you choose, you may submit the **Authorization for Use or Disclosure of Protected Health Information** form. Completing this form allows communication between myself and your child's medical providers. This way I can request physicals, immunization records, and other pertinent medial information directly from your physician's office.

If a student has medications that need to be taken in school, please fill out the enclosed **Medication Order and Parent Consent**. If you have a student who experiences frequent headaches, cramps, or has acid reflux you will need to provide a doctor's order for medication. Students may not self-carry any medication that has not been approved by the health office. All medications must be in its original container, and brought into the health office by the parent/guardian. If this is not possible for you, please contact the health office.

The health office can administer some over the counter medications. Please see the **Over the Counter Permission** form. I must have parental consent to administer these items. PLESAE NOTE: Tylenol, Tums, and Ibuprofen are NOT included on this list. We need a student specific medication order from your provider for these items. Please see above.

If students have had a physical or immunizations over the summer, please send that information in to the health office. Students entering 7th and 10th grade, or any new student to the district, are required by NYS law to have an updated physical on file at the school. This physical must be received within 30 days of the start of the school year.

Please keep in touch with the health office regarding absences. If a student will be absent or late, a parent should call or email in the morning. A written or emailed excuse should also be submitted when the student returns to school. A written note from parents is also required when students need to leave early. This permission cannot be accepted over the phone. If a student is absent for 3 consecutive days, we may ask for a note from your doctor. Our policy requires a doctor's note after 5 consecutive absences.

Please feel free to contact the Health Office with any questions or concerns at 607-869-9636 x4102.

Yours in health,

Dena Ganoung, RN

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Over the Counter Medication Permission for 2017-2018 School Year

Dear Parent or Guardian:

New York State law prohibits the use of any over the counter substance in a school Health Office unless they have been individually prescribed by a physician for each student. During the course of each school day, we see many students for minor cuts, rashes, sore throats, coughs, etc. in order to effectively treat these students we keep a variety of over-the-counter remedies on hand in our office. However, we are no longer allowed to use them without the above mentioned prescription and parental permission.

The items listed below are kept in the health office to be used when deemed appropriate by the school nurse. A brief description of each item is included on the following page. Please complete this form and return it to the health office. We will have the school physician sign it.

PARENTS SHOULD NOTIFY THE SCHOOL OF ANY ALLERGIES TO THE FOLLOWING SUBSTANCES.

Please put a check mark next to any item that we MAY administer to your child:

___ Aloe Gel
___ Anbesol
___ Betadine Solution
___ Biofeeze/Mineral Ice
___ Blistex/ Lip Balm
___ Caladryl
___ Carmex
___ Chloraseptic
___ Cough Drops
___ Eucerin Cream
___ Hydrogen Peroxide
___ Saline drops/Artificial tears
___ Sting-kill swabs
___ Sunscreen
___ Triple Antibiotic Ointment
___ Vaseline

Student Name _____ Date of Birth _____

Parent/Guardian Signature _____ Date _____

As always, please feel free to contact the school health staff at 607-869-9636, ext. 4102 if you have any questions or concerns. Thank you.

Sincerely,

Dena Ganoung, RN
MS/HS Nurse

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Description of Over the Counter Medications

Aloe Gel – topical treatment used for sunburns and other minor burns

Anbesol – topical oral anesthetic used for minor mouth irritations

Betadine Solution – used to wound cleansing, diluted with water before use

Biofeeze/Mineral Ice – a menthol-based pain reliever used to treat sore or strained muscles, painful joints and bruises

Blistex/Lip Balm – lip ointment which provides moisture to soothe dry, chapped lips

Caladryl – calamine lotion containing antihistamine, used for insect bites and rashes

Carmex – lip balm meant to eliminate cold sores and soothe dry, chapped lips

Chloraseptic – topical oral anesthetic, used for sore throats and mouth irritations

Cough Drops – used for coughs, sore throats, and nasal congestion

Eucerin Cream – hypo-allergenic lotion used for dry skin and eczema

Hydrogen Peroxide – topical cleansing agent

Saline drops/Artificial tears – used to flush/hydrate eyes to remove foreign objects or irritants

Sting-kill swabs – topical anesthetic used to beestings and insect bites

Sunscreen – lotion used for sun protection

Triple Antibiotic Ointment – used for minor cuts and abrasions to help healing and prevent infection

Vaseline – petroleum based product used to heal and protect minor cuts and burns

If you would like further information regarding any of these substances, please feel free to call the Health Office at 869-9636, ext. 4102.

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MEDICATION ORDER AND PARENTAL CONSENT

Student Name: _____ Date of Birth: _____

Medication: _____

Dosage: _____

Frequency: _____

Diagnosis: _____

I assess this student to be self-directed: ___ Yes ___ No

Student may self-carry and self-administer medication: ___ Yes ___ No

_____ _____
Medical Provider Signature Date

_____ _____
Medical Provider's Name Practice Phone Number

___ I authorize the school nurse to administer the above medication to my child in accordance with the written order.

___ I authorize my child to self-carry and self-administer the medication listed above. I realize that this will be allowed at the school nurse's discretion.

_____ _____
Parent/Guardian Signature Date

FOR OFFICE USE:

_____ _____
Signature of approving school official Date

SOUTH SENECA
CENTRAL SCHOOL DISTRICT

South Seneca Middle / High School
7263 S. Main Street, Ovid, NY 14521
Tim Houseknecht, Principal

Ph. 607-869-9636 www.southseneca.org Fax: 607-869-9553

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below:
Name_____Phone_____FAX_____Name_____
_____Phone_____FAX_____Name_____
_____Phone_____FAX_____

to release the medical records of my child, _____, DOB _____ to the district's: ❒ Medical Director ❒ School Nurse ❒ Athletic Trainer (AT) ❒ Counselor ❒ Occupational Therapist (OT) ❒ Physical Therapist (PT) ❒ Psychologist ❒ Social Worker ❒ Speech Therapist (ST)
❒ other _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)
❒ Immunizations ❒ Health Appraisals ❒ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ❒ Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: check all that apply)
❒ To develop care or therapy plans for routine and emergent school management
❒ To design appropriate educational, school, or athletic programs
❒ To assess the impact of the medical condition(s) on school programming and/or attendance
❒ To share school observations/concerns surrounding behavior
❒ To assess a medical basis for modification of transportation and/or home tutoring
❒ Medication delivery or therapy prescriptions
❒ At patient's request with no specified purpose
❒ Other_____

PARENT: Please select one.
❒ This authorization is valid for the entire academic school year 20 - 20
❒ This authorization is valid for the duration of attendance within the school district
❒ This authorization shall expire on ____/_____/_____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____ Signature of Parent/Guardian or student if over 18 Relationship Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) **The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:**

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp)

Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.