Bethel Baptist Christian Academy
200 Hunt Road, Jamestown, NY 14701
Website: bbcajamestown.weebly.com

Phone: 716-484-7420
Fax: 716-484-0087
Email: bbcaoffice03@gmail.com

Emergency Medical Treatment Form

Student's Name _____ Date of Birth _____ Grade _____

Part 1 – NEW STUDENTS ONLY

1. Immunizations: All new students are required to provide official immunizations to BBCA within the first 30 days of school. Official records would be either immunization records from a previous school or a copy from a doctor's office/clinic.
2. All new students must provide documentation of a current physical within the past 12 months.

Part 2 – All students

1. Please note any information that would be helpful to an attending physician in a medical emergency.
   - ❑ My child wears contacts ____Yes ____No
   - ❑ My child has the following allergies: _____
   - ❑ My child has this special condition _____
   - ❑ My child takes the following prescription drugs _____
   - ❑ Other relevant and appropriate information___ _____

   Date of last tetanus shot (month/year) ___/___
2. Family's Physician's Name _____ Phone _____
   Hospitalization Coverage: _____ _____
   Insurance Company or Govt. Program I.D. or Contact #
3. Permission is granted for the student named above to travel with BBCA athletic teams, or any school sponsored function, to and from games, or functions, by bus (or car if necessary).
4. In case of emergency we ❑ do ❑ do not give permission for medical treatment at the nearest medical facility if deemed advisable by the person in charge. This permission is also granted for home games when we cannot be contacted.

Emergency Phone Numbers

Home (____) ____-_____ Father's Work (____) ____-_____/ cell # - _____

Mother's Work (____) ____-_____/ cell # - _____

Other Emergency Contact (____) ____- _____Name & Relationship to student _____

Other Emergency Contact (____)____-_____Name & Relationship to student_____

5. We will not hold BBCA responsible for accident/injury liability, either during school hours or during extra-curricular activities including athletic contests, class trips, and class socials.
6. We agree that the above information may be shared with appropriate faculty/staff or health care providers if deemed advisable by the person in charge.

Signatures of both parents (or guardians) are required.

_____ _____ _____ _____

Mother Date Father Date

BETHEL BAPTIST CHRISTIAN ACADEMY STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (kidney, testicle)
☐ Skin Conditions
☐ Speech Condition
☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes:_____

Please list any additional concerns: (use back of sheet if necessary)_____

_____

Parent/Guardian
Signature:_____Date:_____

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: Bethel Baptist Christian Academy **Phone 484-7420** **Fax 484-0087** **Gender:** ❑ M ❑ F **Grade:** _____

200 Hunt Road, Jamestown, NY 14701 **Email: bbcaoffice03@gmail.com**

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: _____
PPD: ❑ Positive ❑ Negative ❑ Not done Date: _____
Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: _____
Dental Referral ❑ Yes ❑ No ❑ Not done Date: _____

Significant Medical/Surgical History: ❑ See attached _____

Allergies: ❑ LIFE THREATENING ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ B/P: _____ AP: _____ Date of Exam: _____

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):

❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ Pass 20 db sc both ears or:	R	L	

❑ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❑ Negative ❑ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ❑ None ❑ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❑ Yes ❑ No Student may self carry and self administer medication ❑ Yes ❑ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❑ **Specify medical accommodations needed for school:** _____ ❑ None

❑ **Known or suspected disability:** _____ ❑ Please monitor

❑ **Restrictions:** _____ ❑ Please monitor

❑ **Protective equipment required:** ❑ Athletic Cup ❑ Sport goggles/impact resistant eyewear ❑ Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension
❑ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 2/08*

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PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Child's Name _____ **D.O.B.** _____ **Grade** _____

To be completed by the licensed health care prescriber:

I request that my patient, as listed above, receive the following PRESCRIPTION MEDICATION:

Diagnosis: _____

Medication	Dosage	Frequency	Route	Time	Duration

Possible side effects and adverse reactions (if any): _____

Student is designated 'Self-Directed' (carries and/or administers own **asthma** medication): ☐ Yes ☐ No

Other Information _____

I request that my above listed patient may receive the following OVER-THE-COUNTER MEDICATIONS during school hours (and extra-curricular activities) to be given as directed on label following age specific guidelines. Please circle all medications that BBCA may administer.

Acetaminophen (pain reliever) Ibuprofen (pain reliever) Tums (antiacid)

Mentolyptus (cough drops) Neosporin (antibiotic cream) Vit C Defense (supplement drops)

Hydrocortisone (anti itch cream) Refresh Plus (lubricant eye drops)

Name of licensed prescriber and Title (please print): _____

Prescriber's Signature _____ Date _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 2/08*

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Dental Health Certificate

Parent/Guardian: New York State law (Chapter 251) 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-uo during this school year to assess his/her fitness to attend school. Please complete **Section 1** and take the form to the dentist for an assessment. If your child had a dental checkup before he/she started school, ask your dentist to fill out **Section 2**. Return the completed form to the 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: / / Sex: ___ Male Grade _____
month day year ___ Female

Will this be your childs' first visit to a dentist? ___Yes ___No

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 Name (print) _____ Date _____

Parent's Signature _____

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 Bethel Baptist Christian Academy.

☐ No, the student listed above is NOT in fit condition of dental health to permit his/her attendance at Bethel Baptist Christian Academy.

NOTE: NOT in fit 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 BBCA 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 and open cavity).

☐ Yes ☐ No Untreated Caries - Does the child have an open cavity? [At least 1/2 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 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.

2/18/2016