Henry Viscardi School Annual Physical Report

Student Information

Name: Sex: M ☐ F☐ DOB: **Date of Exam:**

Diagnosis: _____ ICD 10 Code(s):

_____

Health History

Allergies: EpiPen/Anaphylaxis Care Plan and orders attached ☐

Pulmonary: Tx form attached ☐ **Cardiac:**

Asthma: No☐ Yes ☐type: Medication☐ Tx form attached Asthma Care Plan Attached ☐

Seizures: ☐ Yes type _____ Emergency Medication ☐ Tx form attached Seizure Care Plan Attached☐

Last seizure_____

Diabetes: No ☐ Yes☐ type_____ Last HgA1c result/date_____ Diabetes Medical Mgmt Plan attached ☐

BMI: Percentile (Weight Status Category): Hyperlipidemia: No☐ Yes☐ Hypertension: No☐ Yes☐

Diet: Regular☐ Restrictions: _____ Thickened fluids ☐ nectar☐ honey☐ NPO☐

Gastrostomy feedings:☐ Tx form attached **GU**_____☐Tx form attached (catheterization)

Surgeries/Hospitalizations: type/date

_____ _____

_____ _____

Medications at home:_____ _____ _____

_____ _____ _____

Medications to be given at school: ☐ Tx form attached

Physical Examination

Height: Weight: BP: Pulse: RR: O2 Sat:

Mental Health:_____

☐System Review and Exam Entirely Normal Please attach Tx form with any orders

Check any assessment boxes outside normal limits and note abnormalities

☐HEENT _____ ☐ABD _____

☐Dental _____ ☐ Back/Spine _____

☐CV _____ ☐Extremities _____

☐PULM _____ ☐GU _____

Trach _____ ☐ Skin _____

Vent _____ ☐ Neuro _____

BiPap _____ ☐ Speech _____

Cough Assist _____ ☐ Soc/Emotional _____

Other _____ ☐ Musc/skel _____

Screenings

Sickle Cell Screen: pos ☐neg ☐ Date:_____ Lead Level (Required Grades Pre-K & K) Date_____Level_____

Vision: Distance Acuity R 20/ L 20/ Hearing: Pure Tone Screening R dB L dB

Date: Distance with Lenses R 20/ L 20/ Date:_____ Referral Yes ☐

_____ Near Vision R 20/ L 20/

Vision Color Pass ☐ Fail☐

Referral Yes ☐ No ☐

Scoliosis: Neg ☐ Pos ☐ Deviation Degree: Trunk Rotation Angle: Referral: Yes ☐ No☐

Clearance for participation in adaptive physical education, adaptive swimming, playground, non-contact basketball, adaptive afterschool programs (Recreation, RAMP, Independent Overnight Living), off-premise trips, Senior trip (may include an overnight)

☐ **Full activity** **Restrictions:** _____

Immunizations- Please Attach Record

Health Care Provider

Signature_____ Date:_____

Name:_____ Stamp:

Address:_____

Phone: _____

Fax:_____

Please Return to School When Complete. HVS Medical Office phone 516 465 1650 Fax 516 465 3742

Henry Viscardi School Medication/Treatment Form

Student Information

Name: **Diagnosis:**

DOB: **Wt:** **Allergies:** **Date:** **ICD10:**

Over the Counter Medications-Dosed on student's weight and package directions. Please initial approved medication

Acetaminophen ☐ Ibuprofen ☐ Benadryl PO ☐ Bacitracin Ointment ☐ Calamine Lotion ☐

Sunscreen ☐ 1% Hydrocortisone cream ☐ Tums (crushed if necessary) ☐ Saline Eye Rinse ☐

Emergency Rx Medication(s)

EpiPen ☐ 0.15mg ☐ 0.3mg ______ Indication Diastat ___ mg PR ______ Indication

Intranasal Midazolam ___ mg ______ Indication

Respiratory Medication(s)

Albuterol 1 unit dose via Neb q ______ Indication Albuterol 2 puffs MDI q ______ Indication

Other: ______ Indication

RX Medication(s) During School AND At Home
We request both as some students stay for afterschool and weekend programs – Attach extra forms if necessary

Medication: ______
Preparation/Concentration: ______
Dose: ______ Route: ______
Standing Dose (s) ☐ at ______ Time
&/or PRN ☐ ______ Specify signs, symptoms, or situations and frequency
Permission to give missed dose at parent's request? Yes ☐

Medication: ______
Preparation/Concentration: ______
Dose: ______ Route: ______
Standing Dose (s) ☐ at ______ Time
&/or PRN ☐ ______ Specify signs, symptoms, or situations and frequency
Permission to give missed dose at parent's request? Yes ☐

Medication: ______
Preparation/Concentration: ______
Dose: ______ Route: ______
Standing Dose (s) ☐ at ______ Time
&/or PRN ☐ ______ Specify signs, symptoms, or situations and frequency
Permission to give missed dose at parent's request? Yes ☐

Medication: ______
Preparation/Concentration: ______
Dose: ______ Route: ______
Standing Dose (s) ☐ at ______ Time
&/or PRN ☐ ______ Specify signs, symptoms, or situations and frequency
Permission to give missed dose at parent's request? Yes ☐

Medication: ______
Preparation/Concentration: ______
Dose: ______ Route: ______
Standing Dose (s) ☐ at ______ Time
&/or PRN ☐ ______ Specify signs, symptoms, or situations and frequency
Permission to give missed dose at parent's request? Yes ☐

Medication: ______
Preparation/Concentration: ______
Dose: ______ Route: ______
Standing Dose (s) ☐ at ______ Time
&/or PRN ☐ ______ Specify signs, symptoms, or situations and frequency
Permission to give missed dose at parent's request? Yes ☐

Treatment(s)

Urinary Catheterization ______ (catheter size, frequency)
Additional catheterization PRN at student's or parent's request? Yes ☐

Gastrostomy Feeding ______ (formula, amt, time/frequency, bolus or pump- ml/hr)
Permission to bolus if pump ordered and not available? Yes ☐

Pulmonary - equipment settings

O2 ______ Amount/Indications BiPap ______ Settings/Indications Cough assist ______ Settings/Frequency/Indications
Trach ______ Vent settings ______

Health Care Provider

Print Name: ______
Address: ______
Phone: ______
Fax: ______
License: ______
Provider Signature: ______ Date: ______ NPI number: (required) ______

Parent Signature: ______ Relationship: ______ Date: ______

Please Return to HVS Medical Department When Complete - Phone 516 465 1650 Fax 516 465 3742

PRESCRIPTION/RECOMMENDATION FOR SCHOOL BASED RELATED SERVICES

Student's Name: _____ **DOB:** _____

District: _____ **SCHOOL:** Henry Viscardi School

The child named above has been recommended for the following service by his/her school district In accordance with the Individualized Education Program designed by the Committee on Special Education.

Period of Service: School Year 7/11/2022 – 6/23/2023

As per the Student's 2022-2023 Individual Education Program (IEP)

Diagnosis (ICD10 Code) Required

_____

Service/Therapy
Please check any that apply

☐ Occupational Therapy ICD10 Code _____
☐ Physical Therapy ICD10 Code _____
☐ Speech Therapy ICD10 Code _____
☐ *Nursing Services ICD10 Code _____

Nursing Services require a specific doctor's order with detailed instructions

ICD10 Code:

Diagnosis: Reason /Need for Ordered Services: _____

Referring Physician/Nurse Practitioner/Speech/Language Pathologist

Please complete all highlighted sections

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code** _____

Phone Number: ( )_____/( ) _____

***License Number:** _____

***NPI #:** _____

***Medicaid Provider ID#**_____
**License, NPI & Medicaid numbers are REQUIRED

*_____ *_____
Signature of Physician/Nurse Practitioner/Speech/Language Pathologist **Date**
(Must be original signature – RX with stamped signature will not be accepted)

Please return completed form to: **Jeanette Glover**
Henry Viscardi School
201 I.U. Willets Road, Albertson, New York 11507
T: 516-465-1673 F: 516-465-3740

4/14/2022

Henry Viscardi School
Release for Medical Information

Date:_____

I _____ give my permission for medical information to be released to the Henry Viscardi School.
I agree that all information may be shared concerning the medical treatments and records for my daughter/son_____,
as necessary.

_____

Signature of Parent/ Guardian