GARDEN SCHOOL

Jackson Heights, New York

Christopher Herman, *Head of School*

Spring 2022

Dear Camp Families:

We would like to extend a warm welcome to our returning camp families as well as to all the new camp families joining us for the first time. The Summer Staff and School's Senior Leadership Team are excited to open our camp doors once again to your family.

Attached you will find:

- The DOHMH (Department of Health and Mental Hygiene) requires that each camper have both a current **Health Form** and an **Aquatic Consent Form** on file - both are attached.
- Allergy Alert and Asthma Medication Administration Forms should be completed only if they pertain to your child. Please have these forms completed and returned to us ***before* your child's first day of camp.**
- A Supply List for each of our groups as well as a tentative schedule to give you an idea of what the day looks like.
- A "Non-Medication Consent Form – this form is authorizing the Health Director to administer over-the-counter medication … this includes sunscreen products.
- Authorized Escorts List Form – Must be completed if anyone other than a parent is authorized to pick up your camper.

You will be receiving an invoice under separate cover indicating the weeks your child is scheduled to be in our program (as indicated on the registration form) and the balance due on your account. So that we may properly staff our program, it is important that any changes to your child's schedule be made prior to May 13th. Payment in full is also required by that date.

Whether your camper is a Honey Bee (Ages 2 & 3), a Caterpillar (Ages 3-5), a Butterfly (Ages 5,6 & 7), a Monarch (Ages 8,9 & 10), a Swallowtail (Ages 11-13), or a Dragonfly (Ages 13+) be assured Summer 2022 will be filled with new adventures.

If there are any additional questions, please feel free to contact us at campdirector@gardenschool.org.

We are looking forward to an exciting summer experience.

The Senior Leadership Team

**** We continue to monitor, review and follow all COVID safety protocols as they become available through the CDC, the NYC Department of Health, the American Camp Association, the American Camp Nurse's Association, and local/state/federal guidance and guidelines ***

Garden School

Jackson Heights, New York

Christopher Herman, M.Ed.., *Head of School*

Garden Camp Medical Consent

Student's Name _____ Date of Birth _____

Address _____

_____

Telephone _____

Parent/Guardian _____

Emergency Contact Number _____

Parent/Guardian 2 _____

Emergency Contact Number _____

Pediatrician Name _____

Pediatrician Phone _____ Pediatrician Fax _____

Parent/Guardian will be notified as quickly as possible in case of an emergency. Please sign below to grant Garden School and its agents permission to dispense over-the-counter medications as needed and to make decisions (including calling an ambulance) to secure medical treatment in an emergency.

Parent/Guardian Signature _____ Date _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex ☐ Female ☐ Male	Date of Birth *(Month/Day/Year)*
				___/___/____

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough	State	Zip Code	School/Center/Camp Name	District ___ Number ___	Phone Numbers
					Home _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email | Cell _____ | Work _____

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications *(attach MAF if In-school medication needed)*

☐ None ☐ Yes *(list below)*

PHYSICAL EXAM Date of Exam: ___/___/___

Height	_____ cm	(___ ___ %ile)
Weight	_____ kg	(___ ___ %ile)
BMI	_____ kg/m²	(___ ___ %ile)
Head Circumference *(age ≤2 yrs)*	_____ cm	(___ ___ %ile)
Blood Pressure *(age ≥3 yrs)*	_____ / _____	

General Appearance:

☐ Physical Exam WNL

	NI	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number _____ Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

							IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Polio 3	___/___/___

Tdap	___/___/___	___/___/___			
MMR	___/___/___	___/___/___	___/___/___		
Varicella	___/___/___	___/___/___	___/___/___		
Mening ACWY	___/___/___	___/___/___	___/___/___		
Hep A	___/___/___	___/___/___	___/___/___		
Rotavirus	___/___/___	___/___/___	___/___/___		
Mening B	___/___/___	___/___/___	___/___/___		
Other _____	___/___/___	_____	___/___/___		

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* — **ICD-10 Code**

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

DOHMH ONLY **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent _____

Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): _____

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number: CAMIS#	17. Program telephone number:
Garden School	40490669	718-335-6363

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:

21. Staff's signature:

X

Garden School

Jackson Heights, New York

Christopher Herman, M.Ed.., *Head of School*

Allergy Alert Form
Summer Camp 2022

This form is to be used for all allergies, including food allergies.

Student's Name _____

Date of Birth _____ Grade _____

Allergic to: _____

_____

How long before symptoms appear? _____

What symptoms does the child experience?

Mouth: _____

Throat: _____

Skin: _____

GI Tract: _____

Lungs: _____

Heart: _____

Emergency action to be taken:

If ingestion and/or contact is suspected:_____

_____

If epipen is prescribed:

- Administer epipen and call 911.
- Tell the dispatcher, "_____ allergy anaphylaxis. Epipen given at _____ (time)."
- Remain on the phone until dismissed by dispatcher.

If other medication is prescribed, please specify type, treatment and dosage:

_____

_____

Parent/Guardian: _____ Phone _____

Parent/Guardian: _____ Phone _____

Parent/Guardian's Signature_____ Date _____

Physician's Signature _____ Date _____

Stamp here with name and license number

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

Student Last Name	First Name	Middle	**Date of birth** ___/___/_____ MM DD YYYY	☐ Male ☐ Female
OSIS Number __ __ __ __ __ __ __ __ __	**Weight** _____kg			
School (include ATSDBN/name, number, address and borough)			**DOE District**	**Grade** / **Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	**Specify Allergy**	**Specify Allergy**
☐ Allergy to	☐ Allergy to	☐ Allergy to

History of asthma?	☐ Yes (*If yes, student has an increased risk for a severe reaction)*	☐ No	**Does this student have the ability to:**	
History of anaphylaxis?	☐ Yes Date ___/___/_____	☐ No	Self-Manage *(See 'Student Skill Level' below)*	☐ Yes ☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes ☐ No
Treatment	Date ___/___/_____		Recognize/avoid allergens independently	☐ Yes ☐ No

Select In School Medications

1. SEVERE REACTION

A. Immediately administer epinephrine ordered below, then call 911.

☐ 0.15 mg
☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for **any** of the following symptoms *(retractable devices preferred)* :

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:_____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

B. If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

C. Give antihistamine after epinephrine administration (*order antihistamine below*)

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

2. MILD REACTION

A. Give antihistamine: Name:_____ Preparation/Concentration:_____ Dose:_____ Route: _____
Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for **any** of the following symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other: _____

B. If symptoms of severe allergy/anaphylaxis develop, or if more than one symptom from each system is present, use epinephrine and call 911.

Student Skill Level *(select the most appropriate option)*
☐ Nurse Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

3. OTHER MEDICATION

- Give Name:_____ Preparation/Concentration:_____ Dose: _____

Route:_____ Frequency: Q_____ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:_____
If no improvement, indicate instructions:_____
Conditions under which medication should not be given: _____

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

Home Medications *(include over-the counter)*

Health Care Practitioner Name LAST	FIRST	Signature	
(Please print and circle one: MD, DO, NP, PA)			Date ___/___/_____
Address			
NYS License # **(Required)**	NPI #	Tel. (____)____-____	Fax. (____)____-____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20 **PARENTS MUST SIGN PAGE 2 →**

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2020–2021

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the allergy services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child epinephrine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: If you decide to use stock, you must send your child's epinephrine, asthma inhaler and other approved self-administered medications on a school trip day and/or after school programs in order that he/she has it available. Stock medications are only for use by OSH staff in school only.

Student Last Name	First Name	MI	Date of birth __/__/____	School
School ATSDBN/Name			Borough Select Borough	District
Parent/Guardian's Name (Print)		SIGN HERE	**Parent/Guardian's Signature**	**Date Signed** __/__/____
Parent/Guardian's Email			**Parent/Guardian's Address**	

Telephone Numbers: **Daytime** (___)___-____ **Home** (___)___-____ **Cell Phone** (___)___-____

Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number** (___)___-____

For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name Date __/__/____ **Reviewed by:** Name Date __/__/____

☐ **504** ☐ **IEP** ☐ **Other** **Referred to School 504 Coordinator:** ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor *(For supervised students only)* ☐ School Based Health Center

Signature and Title (RN OR SMD): **Date School Notified & Form Sent to DOE Liaison** __ / __ / ____

Revisions as per OSH contact with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential Information should not be sent by email

FOR PRINT USE ONLY

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2021-2022

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle Initial: _____ Date of birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ DOE District: ____ Grade/Class: _____

School (include: ATS DBN/Name, address, and borough):

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other: _____

Control (*see NAEPP Guidelines*)
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity (*see NAEPP Guidelines*)
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐ Y	☐ N	☐ U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐ Y	☐ N	☐ U	
History of asthma-related PICU admissions (ever)	☐ Y	☐ N	☐ U	
Received oral steroids within past 12 months	☐ Y	☐ N	☐ U	____ times last: _____
History of asthma-related ER visits within past 12 months	☐ Y	☐ N	☐ U	____ times last: _____
History of asthma-related hospitalizations within past 12 months	☐ Y	☐ N	☐ U	____ times last: _____
History of food allergy or eczema, specify: _____	☐ Y	☐ N	☐ U	

Student Skill Level (select the most appropriate option):

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry/self-administer
  - ☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events - Practitioner's Initials: _____

Quick Relief In-School Medication

☐ **Albuterol** [Only generic Albuterol MDI is provided by school for shared usage]
(plus individual spacer): ☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standard Order: Give 2 puffs q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE.**

If in Respiratory Distress: Call 911 and give 6 puffs; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs 15-20 mins before exercise.

☐ **URI Symptoms/Recent Asthma Flare:** 2 puffs @noon for 5 school days.
Special Instructions: _____

☐ **Other:** Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: _____ hrs
Give _____ puffs/ _____ AMP ☐ _____ hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath.
Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.
If in Respiratory Distress: Call 911 and give _____ puffs/ _____ AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** _____ puffs/ _____ AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** _____ puffs/ _____ AMP @ noon for 5 school days
Special Instructions: _____

Controller Medications for In-School Administration

(*Recommended for Persistent Asthma, per NAEPP Guidelines*)

☐ **Fluticasone** [Only Flovent® 110 mcg MDI is provided by school for shared usage]
☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standing Daily Dose: ____ puffs ONCE a day at ____ AM

Special Instructions: _____

☐ **Other ICS Standing Daily Dose:**
Name: _____ Strength: _____ Dose: ____ Route: _____ Frequency: ____ hrs

Home Medications (include over the counter) ☐ None

☐ Reliever: _____ ☐ Controller: _____ ☐ Other: _____

Health Care Practitioner

Last Name (Print): _____ First Name (Print): _____ Signature: _____

NYS License # (Required): _____ **Please check one:** ☐ MD ☐ DO ☐ NP ☐ PA Date: _____

Tel: _____ FAX: _____ NPI #: _____

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

FORMS CANNOT BE COMPLETED BY A RESIDENT

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

PARENTS MUST SIGN PAGE 2 +

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year 2021-2022

Please return to school nurse. Forms submitted after June 1, 2020 may delay processing for new school year

PARENTS/GUARDIANS READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment, including non-albuterol inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma medicine is not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the doctor's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
   - When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner may fill out a new MAF so my child can continue to receive health services through OSH. My health care practitioner or the OSH health care practitioner will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
   - This form represents my consent and request for the asthma services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved self-administered medications with your child on a school trip day and/or after-school program in order for he/she to have it available. Stock medications are for use by OSH staff in school only.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School (ATS DBN/Name): _____ Borough: _____ District: _____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Parent/Guardian Cell Phone: _____ Other Phone: _____

Other Emergency Contact Name/Relationship: _____

Other Emergency Contact Phone: _____

For Office of School Health (OSH) Use Only

OSIS Number: _____ **Received by -** Name: _____ Date: _____

☐ 504 ☐ IEP ☐ Other _____ **Reviewed by -** Name: _____ Date: _____

Referred to School 504 Coordinator: ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only)

☐ School Based Health Center ☐ OSH Asthma Case Manager *(For supervised students only)*

Signature and Title (RN OR MD/DO/NP): _____

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified

Confidential information should not be sent by email

FOR PRINT USE ONLY

Garden School

Jackson Heights, New York

Christopher Herman, M.Ed.., *Head of School*

Aquatic Consent Form

I do hereby give consent for my child, _____, age, _____, to participate in the Aquatics Program at the Garden Summer Camp for Summer 2022 under the supervision of the Aquatics Director.

Signature: _____

Relationship to Child: _____

Date: _____

Daytime Telephone: _____

Garden School

Jackson Heights, New York

Christopher Herman, M.Ed.., *Head of School*

Photo Release Form

Parent / Guardian Name: _____

Child(ren) Name(s): _____

Grade(s): _____

Please check appropriate box to indicate your preference:

☐ I do not wish my child's pictures to be used for any purpose.

☐ I allow my child's picture to be taken to be used in marketing materials

Parent / Guardian Signature _____ Date _____

Garden School

Jackson Heights, New York

Christopher Herman, M.Ed.., *Head of School*

Summer Camp Supply List

Honey Bees, Caterpillars and Monarch Programs (Ages 2 – 7)

- Reusable cup with your child's name on it for water
- Complete change of clothing in labeled zip lock bags
- Family picture
- Two bathing suits to be taken home each night
- A hooded towel to be taken home each night
- Water shoes
- Waterproof bag
- Hat and spray-on sunscreen
- Diapers and wipes (Honey Bees only)
- Light resting blanket or towel for full-day children (Honey Bee & Caterpillar program only)
- Face mask
- Lunch from home; if cold, send in an insulated bag, use of a thermos is suggested for hot lunch – reheating is not available.

Monarchs, Swallowtails or Dragonflies (Ages 8 - 13+)

- Two bathing suits
- A beach towel
- Shoes to walk to and from the pool
- Hat
- Reusable water bottle
- Waterproof bag
- Sunscreen
- Lunch from home – see above
- Face mask

NOTES

- First day of camp is June 13th, 2022
- Bus notification – you will be contacted the weekend before camp begins with the approximate time of pick up. Thank you for your patience as the first few days of transportation are not always smooth as we learn the most efficient routes. Pick-up times will become consistent.
- Camp ***will not*** be in session Monday, July 4, 2022, in observance of Independence Day.

NYC Health

Authorized Escorts List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/ guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/ guardian as a person who is authorized to escort a child out of the center.

Instructions: *The parent/ guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized escort information.*

I, _____, authorize this child care center to release my child,
(parent/ guardian name)

_____, to the individuals I have identified below.
(child name)

Name:			
Relationship to child:			
Home address:			
Preferred contact:	☐ Mobile/Cell Telephone ☐ Text (Mobile)	☐ Home Telephone ☐ E-mail	☐ Work Telephone
Telephone:	*Mobile/Cell:*		
	Home:	*Work:*	
E-mail:			

Name:			
Relationship to child:			
Home address:			
Preferred contact:	☐ Mobile/Cell Telephone ☐ Text (Mobile)	☐ Home Telephone ☐ E-mail	☐ Work Telephone
Telephone:	*Mobile/Cell:*		
	Home:	*Work:*	
E-mail:			

Parent/ Guardian Signature: _____

Date: _____

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.