Principal
Frank Panasci
fpanasci@sachem.edu

Assistant Principals
John Galligan, Ed.D
Donna Gregory

Superintendent of Schools
Christopher J. Pellettieri, Ed.D

57 Division Street
Holtsville, NY
11742
631.696.8600

#WeAreSachem

Sachem Central School District

Sagamore Middle School

Date: June 2022

Dear Parent or Guardian:

We wanted to remind you for next year that New York State Law requires ALL 7th Grade Students to have a **physical examination & a Meningitis Vaccine**.

For your convenience, a physical exam form and dental certificate is enclosed for your healthcare providers. Please have your family physician complete, sign and stamp the enclosed physical examination form and return to our office.

If they have already had a physical on or after September 6, 2021 that is acceptable and you can send them to us now. Also, if they have had their Meningitis vaccine and you have not sent in proof of that, please do so now.

You may mail in, email or fax (see below) your physicals & proof of the Meningitis Vaccine or make arrangements to drop them off to Sagamore.

We will be accepting medications/medication forms, medical notes, medical supplies, physicals, sport physicals, green cards and immunizations towards the end of the summer on:

August 22, 23, 30 and 31 from 7:30 AM -2:00 PM

We encourage you to take advantage of these drop off dates as it makes for a smoother start to your child's first day of classes.

Thank you for your cooperation. If you should have any questions, please feel free to contact us.

STUDENTS A-L:
A.Semler
(asemler@sachem.edu)
631-696-8600 x 3949
Fax: 631-696-8647

STUDENTS M-Z
J. Hummel
(jummel@sachem.edu)
631-696-8600 x 3950
Fax: 631-696-8647

Sincerely,

Sagamore Middle School Nurses
A. Semler, RN and J. Hummel, RN

Sachem Central School District

Christopher J. Pellettieri, Ed.D. , Superintendent of Schools

Sagamore Middle School
Frank Panasci, Principal
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Important IMMUNIZATION Information!!!

Dear Parent or Guardian:

There have been significant changes in the New York State immunization requirements for students in grades 7 and 12, beginning in the 2016-17 school year. Children, who were previously immunized, may not meet the new requirements. The key points of the requirements of the law and its implementation are as follows:

On October 26, 2015, Governor Cuomo signed into law Chapter 401 of the laws of 2015 which amended New York State (NYS) Public health Law (PHL) section 2164 to require children entering or attending seventh and twelfth grades on or after September 1, 2016 to receive an adequate dose or doses of vaccine against meningococcal disease as recommended by the Advisory Committee on Immunization Practices (ACIP). Meningococcal meningitis is a serious disease which can lead to death within hours. Survivors may be left with severe disabilities, including the loss of limbs, cognitive deficits, paralysis, deafness, or seizures. In the coming year, the New York State Department of Health (NYSDOH) will work with the New York State Education Department and other partners to draft regulations and establish updated immunization requirements charts and other materials to help implement this new requirement. The ACIP recommendations for meningococcal vaccine are:

- A single dose of vaccine against meningococcal serogroups A, C, W-135, and Y (MenACWY vaccine; brand names Menactra or Menveo) should be administered to all adolescents at age 11 or 12 years.
- A second (booster) dose of MenACWY vaccine should be given at age 16 years.
  - The booster dose is not necessary for adolescents who receive the first dose of MenACWY at 16 years of age or older.
  - The minimum interval between doses of MenACWY vaccine is 8 weeks.
  - A serogroup B meningococcal vaccine series (MenB vaccine) may be administered to adolescents and young adults 16 through 23 years of age, at the discretion of the healthcare provider. The preferred age for MenB vaccine is 16 through 18 years of age.

For additional information, please see the websites below:
NYSDOH Meningococcal Disease Fact Sheet
http://www.health.ny.gov/diseases/communicable/meningococcal/fact sheet.htm
NYSDOH Childhood and Adolescent Immunizations web page:
http://www.health.ny.gov/prevention/immunization /childhood and adolscent.htl

Our records show your child is in need of the following immunization(s):
Meningococcal vaccine
Please bring this form to your child's physician for their review. Please send proof of the required vaccination to your childs school nurse. Thank you for your attention to this very important matter. If you have any questions, please contact your child's building school nurse.
Further information on the new revisions can be found at: www.health.ny.gov/immunization
If your child is not compliant with NYS Guidelines required they will be excluded from school starting on September 6th 2022.

Child's name: _____

Immunization/date: _____

Other recent immunizations/dates: _____

Physician's Signature: _____ Physician's Stamp:

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB-PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre-K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				Not Done
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	☐	☐	☐ Yes ☐ No	☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

Sachem Central School District

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 Condition
- ☐ 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?
☐ No ☐ Yes: _____

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

_____

Parent/Guardian Signature: _____ Date: _____

Sachem Central School District Athletic Participation Form (APF)

Two Page Form Both pages must be completed.

Student Name:		DOB:	
School Name:		Age:	
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12		Level (check): ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	
Sport:		Limitations: ☐ Yes ☐ No	
Date of last health exam:		Date form completed:	

Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back. Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:		Yes	No
General Health Concerns			
1.	Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?		
2.	Have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell trait or disease ☐ Other		
3.	Ever had surgery?		
4.	Ever spent the night in a hospital?		
5.	Been diagnosed with Mononucleosis within the last month?		
6.	Have only one functioning kidney?		
7.	Have a bleeding disorder?		
8.	Have any problems with his/her hearing or wears hearing aid(s)?		
9.	Have any problems with his/her vision or has vision in only one eye?		
10.	Wear glasses or contacts?		
Allergies		**Yes**	**No**
11.	Have a life threatening allergy? If Yes, check any that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other		
12.	Carry an epinephrine auto-injector?		
Breathing/Respiratory Health		**Yes**	**No**
13.	Ever complained of getting more tired or short of breath than his/her friends during exercise?		
14.	Wheeze or cough frequently during or after exercise?		
15.	Ever been told by their health care provider they have asthma?		
16.	Use or carry an inhaler or nebulizer?		

Has/Does your child:		Yes	No
Concussion/Head Injury History			
17.	Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?		
18.	Have you ever had a head injury or concussion?		
19.	Ever had headaches with exercise?		
20.	Ever had any unexplained seizures?		
21.	Currently receive treatment for a seizure disorder or epilepsy?		
Devices/Accommodations		**Yes**	**No**
22.	Use a brace, orthotic, or other device?		
23.	Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.		
24.	Wear protective eyewear, such as goggles or a face shield?		
Family History		**Yes**	**No**
25.	Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Female Only		**Yes**	**No**
26.	Begun having her period?		
27.	Age periods began:		
28.	Have regular periods		
29.	Date of last menstrual period:		
Males Only		**Yes**	**No**
30.	Have only one testicle?		
31.	Have groin pain or a bulge or hernia in the groin?		

Sachem Central School District Medical Athletic Participation Form (APF)-Page 2

Student Name:

School Name: DOB:

Has/Does your child:		Yes	No
Heart Health			
32.	Ever passed out during or after exercise?		
33.	Ever complained of light headedness or dizziness during or after exercise?		
34.	Ever complained of chest pain, tightness or pressure during or after exercise?		
35.	Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?		
36.	Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?		
37.	Ever been told they have a heart condition or problem by a physician? If so, check all that apply: ☐Heart Infection ☐Heart Murmur ☐High Blood Pressure ☐Low Blood Pressure ☐High Cholesterol ☐Kawasaki Disease ☐Other:		
Injury History		Yes	No
38.	Ever been diagnosed with a stress fracture?		

Has/Does your child:			
Injury History *continued*		Yes	No
39.	Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
40.	Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
41.	Have a bone, muscle, or joint injury that bothers him/her?		
42.	Have joints become painful, swollen, warm, or red with use?		
Skin Health		Yes	No
43.	Currently have any rashes, pressure sores, or other skin problems?		
44.	Have had a herpes or MRSA skin infections?		
Stomach Health		Yes	No
45.	Ever become ill while exercising in hot weather?		
46.	Have a special diet or have to avoid certain foods?		
47.	Have to worry about his/her weight?		
48.	Have stomach problems?		
49.	Have you ever had an eating disorder?		

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known. Note: "Yes" answers to any of these questions does not mean automatic disqualification from the athletic activity indicated. They will require review and evaluation by the school physician.

_____

_____

_____

_____

Risk Acknowledgement and Permission: I give permission for to participate in any sports for which the examining physician or school nurse have determined there are no disqualifying conditions. I fully understand that my child may not participate in any practice, scrimmage or contest without proper clearance. Further, I acknowledge that with participation in interscholastic athletics comes the risk of injury. These risks vary from sport to sport and can range form minor to catastrophic in nature. In addition, I also recognize that there are risks involved with team travel to contest sites at opposing school facilities. I give permission for my child to undergo a medical examination by district approved physicians. If I choose to have the examination performed by a family physician, then I agree to have the information completed on the appreciate school forms. I also agree that in some cases, district appointed physicians shall have the right to review the information provided my family physicians and retain the right of final approval. I clearly understand that the questions are asked in order to decide if this student is in proper condition to participate in the sports named at the top of this form. The answers are correct as of the date this form is signed. All answer will be kept confidential in his/her record in the school health office. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Guardian Signature:_____ **Date:**_____

Student Signature:_____ **Date:**_____

SACHEM CENTRAL SCHOOL DISTRICT

Dental Health Certificate

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 1½ 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.