To: The Parents of All Incoming 6th Grade Students
From: Ms. Moschetti, BMMS School Nurse
Date: June 2023

Welcome to Blue Mountain Middle School!

Important information is listed below for your incoming sixth grader:

- These are the requirements **for sixth grade students.** A second varicella vaccine is required **PRIOR** to the start of the school year. Please plan your child's visit to his/her pediatrician accordingly.
- Also, please be sure to schedule your child for his/her **TDAP vaccination** if they have not already received it. This is a New York State requirement for school attendance for ALL 6th grade students. **The school health office must receive documentation of this vaccination upon completion, within 14 days of the student's 11th birthday.**
- If your child will **require medication while in school**, it is necessary to obtain a **physician's order**. The form is attached for your convenience.

Required Immunizations for 6th Grade

Immunization	Number of Doses
Tdap: ● Boostrix® (licensed for use with 10-64 year olds) ● Adacel® (licensed for use with 11-64 year olds)	**Age 10:** Not required to receive the Tdap until they turn 11 years old. At that time they must provide documentation of a booster dose of Tdap or provide proof of an appointment for the booster dose within 14 days. **Age 11:** Must receive an immunization containing tetanus toxoids, diphtheria, and acellular pertussis (Tdap).
DTap	3
Polio	4 (3 Doses if 3rd dose was received at 4 years or older)
MMR	2
Hepatitis B	3
Varicella	2

Please see the Health Services page on the **Hendrick Hudson School District website** (www.henhudschools.org) for access to health related forms, potassium iodide opt out and information.

I look forward to seeing your children in September!!

MEDICATION AUTHORIZATION FORM

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by the parent or guardian:

I request that my child, _____ grade____, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Signature (Parent or Guardian): _____

Address: _____

Phone: Home _____ Work: _____ Date: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to be taken during School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

_____

Other Recommendations: _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____