VSCA

Valley Stream Christian Academy

A Ministry of Bethlehem Assembly of God

12 E. Fairview Avenue
Valley Stream, NY 11580
(516) 561-6122
Middle & High School
(516) 823-0022
Elementary
www.vscaschool.org

June 2025

Dear Parent/Guardian,

This envelope contains important Health Information Forms and NYS law requirements. These documents are separate from the academic registration for VSCA. Please look over them carefully, fill out your part and present the health forms to your child's physician.

A Physical exam done within the past 12 months along with the NYS required vaccinations is mandatory for all new students and students entering grades Pre-K, K, 1, 3, 5, 7, 9, and 11. This packet also contains important immunization requirements for students in grades 6, 7, and 12.

Please return the enclosed health forms to the Elementary or High School offices at the start of the school year in the envelope provided, to the attention of Nurse Kathy.

Please feel free to reach out to me if you have any questions or concerns. I wish you and your family a healthy and happy Summer!

Thank you,
Nurse Kathy

Kathy Page, R.N.
School Nurse
Ph: (516) 823-0022
Email: nurse@vscaschool.org

nassau BOCES HEALTH & ALLIED SERVICES

EMERGENCY INFORMATION AUTHORIZATION CARD

_____ Date of Birth _____ Age _____ Sex _____
(last) (first)

Address _____ Phone _____

Home school district _____ Teacher _____

	Mother/Person in Parental Relationship	Father/ Person in Parental Relationship
Name		
Home Address		
Home Phone		
Cell/Beeper Phone		
Work Phone		
Place of Employment		
Email		

If my child has to be taken home because of an illness or injury and I cannot be reached, please call:

Name	*Address*	*Relationship*	*Phone # (home, cell, office)*	*Alternate Phone #*

Date _____ **Parent's Signature** _____ **OVER →**

In an emergency when you cannot reach either parent, I authorize the school to call:

(Physician's Name)	**(Address)**	**(Phone)**

HEALTH SURVEY

1. When was the student's last physical examination? ***(month/year):*** _____

2. Has the student had any other physician evaluations/examinations since September 1st last year? *(ENT, Ophthalmologist, Psychiatrist, etc.)* ☐ **No** ☐ **Yes**
   If YES, specify _____

3. Has the student had any immunizations, including tetanus injection, since September 1 last year? ☐ **No** ☐ **Yes**
   If YES, specify _____

4. Has the student had any illnesses, serious injuries, operations or communicable diseases since September 1 last year? ☐ **No** ☐ **Yes**
   If YES, specify with dates _____

5. Does the student have any medical conditions that the school should be aware of? *(heart conditions, seizures/seizure disorder, asthma, diabetes, liver or kidney conditions, etc.)* ☐ **No** ☐ **Yes**
   If YES, specify _____

6. Does the student have allergies? ☐ **No** ☐ **Yes**
   If YES, specify _____

7. Does the student take any medication on a regular basis (excluding vitamins)? ☐ **No** ☐ **Yes**
   If YES, specify _____

8. **Additional Comments** _____

Date _____ **Parent's Signature** _____