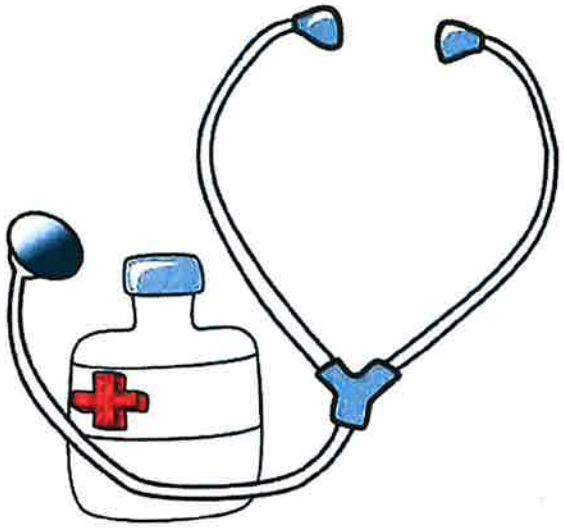
St. Mary Interparochial School
Health Room



To the parents/guardians of Kindergartners and New Students...

All students need to provide a copy of the required immunizations, a current physical and a current dental form PRIOR to the 1st day of school.

Thank you!

Exemptions to the school laws for immunizations are:

- medical reasons;
- religious beliefs; and
- philosophical/strong moral or ethical conviction.

If your child is exempt from immunizations, he or she may be removed from school during an outbreak.

VACCINE SAFETY

- Vaccines are held to the highest standard of safety.
- The United States has the safest, most effective vaccine supply in history.
- Vaccines are continually monitored for safety and effectiveness.

Pennsylvania's school immunization requirements can be found in 28 PA Code Ch.23 (School Immunization).

Contact your health care provider or the Pennsylvania Department of Health at 1-877-PA-HEALTH (1-877-724-3258).

Vaccine information can be found at: www.dontwaitvaccinate.pa.gov

pennsylvania
DEPARTMENT OF HEALTH

Rev. 03/17

PENNSYLVANIA SCHOOL IMMUNIZATION REQUIREMENTS

IMMUNIZE --
Don't Wait. Vaccinate.

Children in **ALL** grades (K-12) need the following **immunizations for attendance:**

- 4 doses of tetanus, diphtheria and acellular pertussis*
  (1 dose on or after 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)
- 2 doses of measles, mumps and rubella**
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

Seventh through 12th Grade ADDITIONAL immunization requirements for attendance:

- 2 doses meningococcal conjugate vaccine (MCV)
  - First dose is given 11-15 years of age; a second dose is required at age 16 or entry into 12th grade.
  - If the dose was given at 16 years of age or older, only one dose is required.
- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap)

* Usually given as DTaP or DTP or DT or Td
* * Usually given as MMR

THE SCHOOL DISTRICT OF PHILADELPHIA
STUDENT MEDICAL INFORMATION

This form is to be used for new students and capturing annual updates.

Last Name:	First Name	Date of Birth	Date:
Name of School:		Room/Section:	Grade:

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by _____

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature _____ **Date**_____

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Does your child have health insurance? __Yes __No Company? _____
2. Where do you take your child for checkups? _____

   Address: _____

   Phone: _____ Fax: _____
3. Date of child's last physical examination? _____
4. Where do you take your child for dental care? _____

   Address: _____

   Phone: _____ Fax: _____
5. Date of child's last dental examination? _____

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School	Room/Section/Book	Date Issued	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature_____ Date_____

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

■ Allergies _____ ■ Date of last PPD_____ Result_____mm

Does this student have health insurance? ___ Yes ___ No Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____
2. Audiometric Screening: R_____ L_____ 3. BP_____
4. Height _____inches / cm Weight _____lb. / kg BMI percentile _____
5. Scoliosis Screening: ____ Normal ____ Abnormal ____ Referred ____ No Referral
6. Activity Recommendation: ____ Full Physical Activity ____ Restricted Physical Activity
   (Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions: _____
7. List all medications currently being taken:
   Medication:_____ Reason:_____
8. List ALL problems by history or examination: Circle status of problem
   1. _____ Under Care Care Complete Referred
   2. _____ Under Care Care Complete Referred
   3. _____ Under Care Care Complete Referred

   ____ No Problems Identified

Comments / follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

THE SCHOOL DISTRICT OF PHILADELPHIA

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments / Follow-up Treatment / Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

_____
Certified School Nurse/Practitioner

_____
School

_____
School Address

_____
Phone Number

THE SCHOOL DISTRICT OF
PHILADELPHIA

Student Emergency /Medical Information

Last Name:_____ First Name:_____ DOB: _____

School:_____ Room/Sec:_____ Grade:_____

Home Address: _____ Home phone: _____

Mother: _____ email: _____ phone: _____

Father: _____ email: _____ phone: _____

Guardian: _____ email: _____ phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child **Phone**

1._____

2._____

Childs Doctor/Clinic: _____ Phone:_____

Medical Insurance: MA___ CHIP____ Private_____

Insurance company name: _____ Policy Number_____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	**YES**	**NO**
Ibuprofen (Advil, Motrin)	**YES**	**NO**

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _____

_____

Other Health Problems: _____

_____

_____

Does your child take medication? ____NO ____YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities. I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature _____ **Date**_____

Revised S-865 (06/2018)

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/ treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT	ADDRESS/ZIP	ROOM/BOOK NO.
DATE OF BIRTH	SCHOOL	PID

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDICATION:	DOSE:
TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:
DATE BEGIN:	DATE END:

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS: _____

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN: _____

RESTRICTION ON ACTIVITY: YES ☐ NO ☐

IF YES, DESCRIBE: _____

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS: _____

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE
ADDRESS	EMERGENCY NUMBER
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

I authorize licensed school personnel to administer the indicated medication as prescribed by my child's health care provider, whose signature appears on this form

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply, as needed regarding this medication and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

In accordance with school district procedure:

- I have assessed the student and s/he has demonstrated competency to self-administer medications.
  YES___ NO_____
- The administration of this medication was approved on:

  _____

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

TO THE PHYSICIAN:
Your patient has requested that medication be administered in school. Ideally, the administration of medication should take place at home. However, for students who require medication during the school day in order to function in the classroom, School District Policy does permit licensed school staff to administer medication. In some cases, students may self-administer their medication.

IF YOUR PATIENT'S MEDICATION CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE REVERSE SIDE· A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT.

Please fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment.

Thank you.

School Health Services

DEAR PARENT/GUARDIAN:

Some children need the administration of medication in order to function in the classroom. Ideally, this should take place at home. If your child's medication schedule cannot be altered and administered at home, you can request the medication to be given in school by seeing the school nurse.

Once the School Nurse has approved the request, you will be required to bring the medication to school properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T-Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

This procedure must be repeated each school year and/or each time there is a change in dosage.

Parents/guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days, or by the last day of school, will be destroyed/discarded.

If you have any questions on this procedure, please contact the school nurse.

. Thank you.