Give to Kindergarten – attach a physical & dental forms

Give to 2nd grade – attach a dental form

Give to 5th graders – attach a physical form

Give to 6th grads – attach a physical form ---TDap & MCV

Dear Parent/Guardian

Vaccines: ALL students MUST have

- 4 doses of **TETANUS, DIPHITHERIA, PERTUSSIS (DTap)** – 1st dose on or after the 4th birthday
- 4 doses of **POLIO**, 4th dose at/after age 4; dose at least 6 months after previous dose.
- 2 doses of **MEASLES, MUMPS & RUBELLA, (MMR)**– 1st dose on/after age 1
- 3 doses of **HEPATITIS B** (properly spaced)
- 2 doses of **CHICKEN POX (VARICELLA)** – 1st dose on/after 1st birthday

7th Graders MUST have:
1 meningococcal & 1 Tdap vaccine

Physical Exam & Vaccine Records: Kindergarten, 6th, 9th graders, NEW students & Students with a Medical Issue.

Your child's doctor is to complete the attached physical exam form. The completed form is then given to the School Nurse. Please make sure that your doctor attaches an updated vaccine record to the physical, as stated on the form.

Scoliosis Screening: 6th & 7th graders MUST have an exam

6th graders- your child's doctor is to perform the scoliosis screening during the physical exam.

7th graders can bring in doctor's results of the scoliosis exam.

6th & 7th Grader: The School Nurse will perform a scoliosis exam if a physical has not been handed in.

Dental Examination: Kindergarten, 3rd, 7th graders & NEW students

The dentist is to complete the attached dental form and then give it to the School Nurse

Medication brought to school must be in pharmacy box as well as have MED-1 and S865 completed **YEARLY**

Every New School Year a doctor must complete the appropriate school district form for each medication that will be given in school. Medication must come to school in the pharmacy box. Contact the School Nurse for further instructions. At the end of the school year a parent/guardian needs to come to school to collect the medication or it will be discarded on the last day of school.

If needed you can get Physicals, Vaccinations, or Dental forms completed at any health Center.

Please stay safe!

Nurse Marjorie

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 ASTHMA 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 _____

. Steps to take during an asthma episode:

- Remove student from any obvious trigger listed above
- **DO NOT** leave student alone.
- Sit student comfortably leaning forward, **DO NOT** insist that they lie down.
- Check student's peak flow reading (if available)
- Give initial treatment of emergency school asthma medication and allow for rest. Improvement from bronchodilators is usually seen within 5-10 minutes after use of inhaler.
- Check for decreased symptoms (or increased peak flow reading)
- Contact parent/guardian to make them aware of asthma episode and effectiveness of treatment.
- If symptoms **DO NOT** decrease after initial treatment with medication, the situation can quickly become an asthma emergency. **CALL 9-1-1 if condition worsens.**

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.

. **Steps to take during an asthma episode:**

- Remove student from any obvious trigger listed above
- **DO NOT** leave student alone.
- Sit student comfortably leaning forward, **DO NOT** insist that they lie down.
- Check student's peak flow reading (if available)
- Give initial treatment of emergency school asthma medication and allow for rest. Improvement from bronchodilators is usually seen within 5-10 minutes after use of inhaler.
- Check for decreased symptoms (or increased peak flow reading)
- Contact parent/guardian to make them aware of asthma episode and effectiveness of treatment.
- If symptoms **DO NOT** decrease after initial treatment with medication, the situation can quickly become an asthma emergency. **CALL 9-1-1 if condition worsens.**

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.

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- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
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- 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.

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School Our Lady of Fort Richmond	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_____

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	

MEH-1 (Rev. 7/19)

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:

M. Karpinski RN, BSN, M.Ed., CSN
Certified School Nurse/Practitioner

Our Lady of Port Richmond
School

3233 Thompson Street
School Address

215-739-1920
Phone Number