

Dear Parent/Guardian

Vaccines: ALL students MUST have

- 4 doses of **TETANUS, DIPHTHERIA, 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

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

**7th Graders MUST have:
1 meningococcal & 1 TDap vaccine**

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 Grader: 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.

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 5865 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

Estimado Padre / Tutor

Vacunas: TODOS los estudiantes DEBEN tener

- 4 dosis de TÉTANOS, DIFITERIA, TOS FERINA (DTap) – 1ra dosis en o después del 4to cumpleaños
- 4 dosis de POLIO, 4ta dosis a/después de los 4 años; dosis al menos 6 meses después de la dosis anterior.
- 2 dosis de SARAMPIÓN, PAPERAS Y RUBÉOLA (MMR)– 1ra dosis al cumplir 1 año o después
- 3 dosis de HEPATITIS B (adecuadamente espaciadas)
- 2 dosis de VARICELA (VARICELA) – 1ra dosis en/después del 1er cumpleaños

Los estudiantes de 7mo grado DEBEN tener:

1 vacuna meningocócica y 1 TDap

Exámenes físicos y registros de vacunas: Kindergarten, 6.º, 9.º grado, estudiantes NUEVOS y estudiantes con un problema médico

El médico de su hijo debe completar el formulario de examen físico adjunto. El formulario completo se le entrega a la enfermera escolar. Asegúrese de que su médico adjunte un registro de vacunas actualizado al examen físico, como se indica en el formulario.

Examen de escoliosis: los estudiantes de 6.º y 7.º grado DEBEN hacerse un examen

Estudiantes de sexto grado: el médico de su hijo realizará la prueba de detección de escoliosis durante el examen físico.

Los estudiantes de 7º grado pueden traer los resultados del examen de escoliosis del médico.

Estudiantes de 6.º y 7.º grado: la enfermera escolar realizará un examen de escoliosis si no se ha entregado un examen físico.

Examen dental: Kindergarten, 3ro, 7mo grado y NUEVOS estudiantes

El dentista debe completar el formulario dental adjunto y luego entregárselo a la enfermera escolar.

Los medicamentos que se traigan a la escuela deben estar en la caja de la farmacia y deben completarse MED-1 y S865 ANUALMENTE

Cada nuevo año escolar, un médico debe completar el formulario correspondiente del distrito escolar para cada medicamento que se administrará en la escuela. Los medicamentos deben llegar a la escuela en la caja de la farmacia. Póngase en contacto con la enfermera de la escuela para obtener más instrucciones. Al final del año escolar, un padre/tutor debe venir a la escuela a recoger el medicamento o se desechará el último día de clases.

Si es necesario, puede completar los formularios de exámenes físicos, vacunas o dentales en cualquier centro de salud.

¡Por favor, mantente a salvo! enfermera 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.

	Yes	No
Acetaminophen(Tylenol)	Yes	No
Ibuprofen (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: _____

The emergency medical and/or dental care, including administration of emergency medications, which may be necessary to preserve the life of my child or to prevent impairment of their health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for on-going care.

Parent/Guardian Signature _____ Date: _____

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 (06/2019)

OPTIONAL

Non-Aerosol Topical Sunscreen Use at School

Parents/guardians may choose to supply their child with non-aerosol topical sunscreen, if it is approved by the U.S. Food and Drug Administration. In order for a student to apply sunscreen during school hours, at a school-sponsored activity, or while under the supervision of school personnel, the parent/guardian must complete the attestations below.

Parent/Guardian Attestation

- By signing below, you confirm that you understand that the school is not responsible for ensuring that the sunscreen is applied by the student.
- By signing below, you confirm that the student has demonstrated that they are able to self-apply the sunscreen.

Parent/Guardian Signature: _____ Date: _____

The school may cancel or restrict the possession, application, or use of a non-aerosol topical sunscreen product by a student if any of the following occurs:

- The student fails to comply with school rules concerning the possession, application, or use of the non-aerosol topical sunscreen product.
- The student shows an unwillingness or inability to safeguard the non-aerosol topical sunscreen product from access by other students.

If a school cancels or restricts the possession, application, or use of a non-aerosol topical sunscreen product by a student, the school shall provide written notice of the cancelation or restriction to the student's parent/guardian.

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 _____

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
<p>TO THE DENTIST <i>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).</i></p> <p><i>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.</i></p> <p><i>Thank you for your cooperation.</i></p>			
UNDER TREATMENT / WORK BEGUN		COMPLETION OF WORK / NO TREATMENT NECESSARY	
Date Work Begun		<input type="checkbox"/> No Treatment Required Now	
Scheduled Follow-up Appointment		<input type="checkbox"/> All Necessary Dental Work Completed	
Date of Dental Examination		Expected Completion Date	
<i>Comments / Follow-up Treatment / Special Instructions to School</i>			
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
SCHOOL HEALTH SERVICES
REQUEST FOR ADMINISTRATION OF ASTHMA MEDICATION**

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)			<p>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</p> <p>My child may self-administer medication/equipment as determined appropriate by the school nurse.</p> <p>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.</p>			
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 <input type="checkbox"/>	NO <input type="checkbox"/>				
IF YES, DESCRIBE: _____						
IS STUDENT TAKING ANY OTHER MEDICATION?	YES <input type="checkbox"/>	NO <input type="checkbox"/>				
IF YES, NAME OF MEDICATIONS: _____						
PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE					
ADDRESS	EMERGENCY NUMBER					
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED					
<table style="width: 100%; border: 1px solid black; padding: 10px;"> <tr> <td colspan="2" style="text-align: center;">In accordance with school district procedure:</td> </tr> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> 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: _____ </td> <td></td> </tr> </table>			In accordance with school district procedure:		<ul style="list-style-type: none"> 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: _____ 	
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PARENT SIGNATURE _____						
TELEPHONE NUMBER _____						
DATE SIGNED _____						
EMERGENCY NUMBER _____						
SIGNATURE OF SCHOOLNURSE _____						
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 | • Prescription Date (current) |
| • Pharmacy Name | • Name of medication, dosage form, expiration date (if relevant) |
| • Pharmacy Address and Phone# | • Instructions for administration |
| • Prescription Number | • 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.