



Mt. Lebanon School District

#415
(rev. 1-19)

New Student Health Packet

Dear Parent(s)/Guardian:

Welcome to our school district. We are pleased that you will be joining our school community and hope that your family finds this to be a healthy and supportive learning environment. Please take a moment to read the following information about our health program and the services provided at school. If your child has special health care needs, requires medication or health treatments during the school day, or has a chronic health condition, please contact your child's certified school nurse so that we can prepare for his/her entry into school.

EMERGENCY INFORMATION: Parents are required to complete the **Emergency Medical Contact/Release Information** page on the parent Dashboard account for the child. This will need to be done when your child's registration is complete and your child has started school in the Mt. Lebanon School District. This will ensure that we have most current contact information. Please follow these tips:

1. You must go in the parent/guardian's Dashboard account, not the account belonging to your child
2. Emergency Medical Contact/Release Information is located under the "account preferences" tab.
3. **Please include parents/guardian (in priority order) as part of your 4 (four) contact options if you wish to be contacted**
4. Please enter this information for each student. You may utilize the "copy form" feature to expedite the process
5. Students with more than one parent account or families who do not have computer access will need to contact their child's health office to request a hard copy of the Emergency Medical Contact/Release Information sheet. Parent/Guardian will then need to complete the form and return it to their child's health office. The health office staff will then transfer the information electronically.
6. If the Emergency Medical Contact/Release Information Sheet is not completed, there will be a deficiency that shows up on your child's and your parent Dashboard account under balance icon. This will be cleared once the Emergency Medical Contact/Release Information sheet is completed or updated. **No money** is due for this.

IMMUNIZATIONS: All students are required to be in compliance with Pennsylvania and Allegheny County Health Department's immunization regulations for school attendance. Please see the attached form **(408-D)** for specific immunization regulations. To comply with these regulations, a copy of your child's immunization record must be submitted, reviewed and approved by the certified school nurse **before** your child can attend school. (please see attached).

KINDERGARTEN: All students entering Kindergarten in Allegheny County will be required to have had **LEAD** testing completed prior to the first day of school. Parents/guardians will need to submit written proof, signed by their child's health care provider of such testing, to their child's certified school nurse.

HEALTH HISTORY: Please complete both sides of the attached health history form **(415-A)** and return to your child's health office. This information is kept confidential and shared with appropriate school and medical personnel as deemed medically necessary.

HEALTH CARE TREATMENTS: Emergency care is available in the health office for any illness or injury that is sustained during school hours. The nurse cannot address injuries that occur at home. By law, a nurse is not permitted to make a diagnosis or prescribe treatment.

Children with an elevated temperature (100 or above), vomiting or diarrhea will need to stay home until symptom free for **24 hours without the use of fever reducing medication.**

The School District adheres to Allegheny County Health Department Guidelines for readmission following a student's communicable disease diagnosis. We are not equipped to provide advanced emergency care. Children needing urgent medical attention will be transported to an emergency care facility by Medical Rescue Team South Authority Ambulance Service, if available or another ambulance service, if needed. Please notify the school nurse if your child has any health concerns that could result in the need for emergency services, or that need to be communicated to emergency personnel.

HEALTH INSURANCE: If your child does not have health insurance, free or low cost coverage is available through Pennsylvania Children's Health Insurance Program (CHIP). CHIP is administered by the Pennsylvania Insurance Department and the coverage is for quality medical services through private health insurance companies. For more information, please visit www.chipcoverpakistan.com or call 1-800-986-KIDS.

Applications are also available in your child's school health office.

HEALTH SCREENINGS: The certified school nurse completes health screenings annually. The schedule is as follows:

- Vision, height & weight, BMI percentile in Grades K-12
- Hearing in grades K thru 3rd grade, grade 7 & grade 11, as well as at parent and teacher requests.
- Scoliosis Screening in grades 6 & 7

Referral forms are mailed home for students who do not pass a school screening and require a more thorough examination by his/her private health care provider.

MEDICATIONS: If a licensed health care provider deems it medically necessary for a student to take medication, either prescription or nonprescription during the school day, the Authorization for Medication Form (#440) signed by the parent/guardian and completed by the licensed healthcare provider, must be returned to the health office with the medication in a pharmacy labeled container. **A separate form is required for each medication. A new, completed form by both the physician and parent is required for each medication change, dose change and for each new school year.**

Emergency medications (Epinephrine auto injector, rescue inhalers and diabetic supplies) may be carried by students after completion of the Authorization for Medication Form #440 and Self Carry Form #440F.

PHYSICAL & DENTAL EXAMINATIONS: Pennsylvania Department of Health requires all students with incomplete health records, students in K, 6 & 11 and any new students to have a physical examination dated no earlier than September 1 of the previous school year. Dental examinations are required for students in grades K, 3, 7 and new students. The school doctor & dentist are available to perform the physical examination or dental examination in school on a limited basis throughout the school year. These school exams are at no cost to you. You may also choose to have your private health care practitioner complete these examinations at your expense.

If you have any questions concerning the preceding topics or other areas pertaining to health services, please contact your child's nurse.

Thank you
Health Services Department.



Mt. Lebanon School District

IMMUNIZATION REQUIREMENTS

408-D (Rev.1/2019)

Pennsylvania and Allegheny County Health department (ACHD) Immunization Requirements per 28 PA Code Chapter 23, Subchapter C, require that all children show proof of immunization **before** they may attend any public, private, charter or home school in the Commonwealth. **Your child will not be permitted to attend school until you have submitted documentation of the required immunizations and they have been received and approved by the Certified School Nurse.**

Students who are entering school are required to have the following properly spaced vaccines:

4 doses of tetanus, diphtheria and acellular pertussis

(1 dose on or after the 4th birthday); 3 doses, if series started after 7 years of age

- Usually given as DTP or DTaP or DT or TD***

4 doses of polio

(4th dose on or after 4th birthday), or 3 doses if 3rd dose started on or after the 4th birthday with proper spacing.

2 doses of measles, mumps, rubella (usually given as MMR)

3 doses of hepatitis B (properly spaced)

2 doses of varicella (chickenpox) vaccine

- or written statement from parent or health care professional indicating month/year of disease***
- or proof of immunity by blood test - giving specific titer***

Kindergarten: Lead testing

Students who are in Grades 7-11 are required to have the following vaccines in addition to the above vaccines:

1 dose of tetanus/diphtheria/pertussis(Tdap)

1 dose of meningococcal conjugate (MCV4 #1)

Students who are entering **Grade 12** are required to have the following vaccine in addition to the above vaccines:

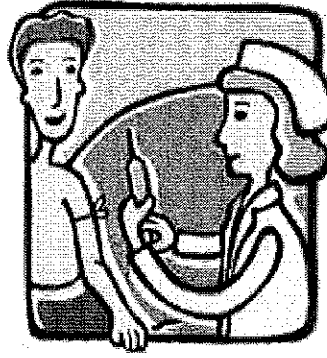
2nd dose of meningococcal conjugate (MCV4 #2)

EXEMPTIONS

MEDICAL Exemption: If the physical condition of your child is such that immunization would endanger life or health, a medical exemption must be submitted. Only licensed medical doctors and doctor of osteopathy and designated Health Department personnel may waive immunization requirements. ***Chiropractors' certification for medical exemptions are not acceptable by law.*** If a medical exemption is for a specific antigen(s) this should be indicated in the statement of exemption. All other immunizations will still be required. These statements of exemption must be written by the appropriate medical personnel and submitted to the Certified School Nurse **prior to your child entering school.**

RELIGIOUS Exemption: This includes a strong or ethical conviction similar to a religious belief. The Certified School Nurse must be notified by the parent in writing of the reasons for this exemption **prior to your child entering school.**

If a child is exempt from immunizations and a vaccine preventable disease outbreak occurs, he/she may be excluded from school per the direction from Allegheny County Health Department.



IMMUNIZATIONS

Allegheny County Health Department immunization clinic offers routine recommended vaccines for children up to the age of 18. Immunizations are FREE of charge for those who qualify.

Children can receive free vaccines at the Allegheny County Health Department clinic if:

- They are on Medicaid
- They have NO health insurance
- Their health insurance does not cover the cost of vaccines
- They are American Indian or Alaskan native

Immunizations are available without an Appointment. Please call the clinic for open dates & times

Allegheny County Health Department **NEW DOWNTOWN LOCATION:**

Hartley Rose Building(near intersection of 1st Avenue & Cherry Way)
425 First Avenue
4th Floor
Pittsburgh, A 15219
Phone: (412) 578- 8062

Public Transportation access via the Port Authority of Allegheny County:

BUS- 42 Bower Hill, exit BLVD of the Allies & Smithfield St
Subway (T stations) - Red & Blue lines **EXIT** 1st Avenue Station

All others should seek immunization services through their Primary Care Physicians (PCP) office.

Allegheny County Health Department(412- 578-8060) will provide school required vaccines, free of charge, to children if they are uninsured, have Medicaid, or are an American Indian or Alaskan Native.



Mt. Lebanon School District

HEALTH HISTORY

415-A
(rev. 1-18)

Student's Name _____ Grade _____ Sex _____

Birth Date _____ Place of Birth _____

Street Address _____ Zip _____ Home Phone _____

Father's Name _____

Mother's Name _____ Maiden Name _____

Person with whom student lives _____

Siblings name	Birth Date	School	Grade

Name and address of school last attended:

Name of school::

Address of school:

Has the student ever been enrolled in Mt Lebanon School District _____
YES NO

If so, When _____ year(s) Where _____

NAME:

TO BE COMPLETED BY PARENT

Please check ✓ ALL that applies to your child

Anxiety		Developmental Delay		Nosebleeds	
Arthritis		Diabetes Type 1		Orthopedic Condition	
Asthma		Diabetes Type 2		Rheumatic Disease	
Attention Deficit Disorder		Dietary Restrictions		Sickle Cell	
Auto Immune Deficiency		Epilepsy/Seizure Disorder		Speech Difficulty	
Bladder/Bowel Control		Gastrointestinal Condition		Spina Bifida	
Bleeding Disorder		Headaches		TB Exposure	
Cooley's Anemia		Hearing Deficit		Thyroid Condition	
Cardiovascular Condition		High Blood Pressure		Tourette's Syndrome	
Cerebral Palsy		Kidney Condition		Vision Deficit(see below)	
Chicken Pox(date)		Malignancy		Eye surgery	
Color Vision Deficiency		Mental Health		Severe loss	
Dental Condition		Neurological Disorder	Contacts or Glasses		

Other _____

Allergies: _____

Reaction _____

Is Medication taken regularly and /or needed for any medical condition?

At home: ____ NO ____ YES Name of Medication _____

At School ____ NO ____ YES Name of Medication _____

(If required at school, complete form #440- Authorization for Medicine)

List and give dates of major operations, injuries, or hospitalization:

1 _____ Date: _____

2 _____ Date: _____

I understand and agree that medical information may be shared with appropriate personnel.

Parent Signature

Date

Signature of Certified School Nurse

Date



Mt. Lebanon School District

Authorization for Medication

#440(1/2018)

Dear Parent/Guardian:

For safety reasons, the administration of student medicines, either prescription or non-prescription, during school hours is strongly discouraged.

If a physician deems it necessary for your child to take medications, either prescription or nonprescription during school day, the **AUTHORIZATION FOR MEDICATION FORM** (reverse side) must be completed by both a parent/guardian and physician and returned to your child's health office prior to any medication being administered.

The following summarizes the procedure:

- Physician orders **MUST** be dated July 1st or after for the upcoming school year.
- Prescription medication must be in the current and appropriate labeled pharmacy container.
- Over the counter medication(nonprescription) must be in the original, unopened container and the type of non-prescription medication must match the physician's orders.
- A new form completed by **both** the physician and parent is required for **each medication**, medication change, dose change and for each new school year.
- It is the responsibility of your child to report to the health office for his/her medication.
- Emergency medications (Epinephrine Auto injector and/or Rescue inhaler) may be carried by students after completion of:

Authorization for Medication Form (#440)

Self Carry Form (#440 F)

Please remember that your child may not receive his/her medication if these procedures are not followed.

Please feel free to contact your child's school certified nurse if you have any questions or concerns regarding this matter.

Thank you for your cooperation.

Health Service Department



Mt. LEBANON SCHOOL DISTRICT HEALTH SERVICES
Authorization for Medication, prescription and non-prescription
to be given during school hours

1/18

Student's Name: _____ ID# _____ School _____

Date of Birth _____ Sex _____ Grade/Homeroom _____

Physician's Name _____ Office Phone Number _____

TO BE COMPLETED BY LICENSED PRESCRIBER:

MEDICATION	
DOSAGE	
TIME OF ADMINISTRATION	
LENGTH OF ADMINISTRATION (i.e. the school year or a shorter time)	
REASON FOR MEDICATION	
ADMINISTRATION INSTRUCTIONS	
SIDE EFFECTS	
SELF-ADMINISTRATION (This student is authorized to self-carry his/her Rescue Inhaler or Auto Injecting Epinephrine and/or Diabetic Supplies and medicate himself/herself.)	YES _____ PHYSICIAN'S INITIALS _____ NO _____ PHYSICIAN'S INITIALS _____
SIGNATURE OF LICENSED PRESCRIBER	
DATE	

TO BE COMPLETED BY PARENT/GUARDIAN:

In consideration of Mt. Lebanon School District granting our request to dispense certain medication to our child and/or allow self-administration of medication, the undersigned parents/guardians, on our own behalf and on behalf of our minor child, hereby release, indemnify and hold harmless Mt. Lebanon School District and its School Board, Administrators, Teachers, Secretaries, Nurses and Employees from and against any and all claims, damages, actions or causes of action resulting and/or arising out of or connected directly or indirectly with the request for or the dispensing of medication listed above to our said child. **I understand and agree the medical information may be shared with appropriate personnel. I authorize my child's physician to release any medical information that may be required by district personnel. I understand and agree that emergency medication may be administered by District employees who are not nurses.**

Parent/Guardian signature _____ Date _____

Home Phone # _____ Work # _____ Cell # _____

Mt. Lebanon School District

1/18

Electronic Emergency Medical Contact/Release Information Request Update

Dear Parent(s)/Guardian:

Parent(s)/Guardian are required to complete an Emergency Medical Contact/Release Information sheet on their children each year. Please check and update your child's emergency Medical Contact/ Release Information page on Dashboard, if not already completed. **A review/revision is required every school year as well as anytime a change is necessary.** Each time a review/revision has been made, please click "**SUBMIT**" at the bottom of the screen and save the review/revision.

The Emergency Medical Contact/ release Information page will be used in the event that your child is ill, injured or there is an emergency. **The Emergency Medical Contact/Release information is requested to ensure the safety and security needs of your children. It is important that the information be as accurate and up to date as possible.**

Please note the following tips:

1. You must go in under the parent/guardian's dashboard account, **NOT** the student's.
2. Emergency Medical Contact/ Release information is located under "account preferences" tab.
3. Please include parents/guardians (in priority order) as part of your four contact options if you wish to be contacted.
4. Please enter this information for each student-you may utilize the "copy from" feature to expedite the process.
5. **If you have completed this information in a previous year, please review it every school year and even if there are no changes, click the submit at the bottom of the screen. This will complete the process and the information will be saved.**
6. Students with more than one parent account or those who do not have access to a computer will need to complete a hard copy of the Emergency Medical Contact/Release Information Sheet. Please contact your child's health office or school secretary for a copy of this.
7. If the Emergency Medical Contact/Release Information Sheet is not completed, there will be a deficiency that shows up on your child's and your parent Dashboard account under the balance icon. This will be cleared once the Emergency Contact/ Release Information Sheet is completed or updated. No money is due for this.
8. Please contact your child's health office for any issues, concerns or if you will need a hard copy Emergency Medical Contact/ Release Information Sheet.

Thank you for your assistance in completing this vital part of your child's health record.

Health Services Department

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH**SCHOOL DENTAL HEALTH RECORD****Complete the following section before the examination/evaluation:**

SCHOOL DISTRICT				COUNTY				DATE OF BIRTH			
STUDENT: LAST		FIRST		MIDDLE		GRADE		SEX M <input type="checkbox"/> F <input type="checkbox"/>			
HOME ADDRESS								TELEPHONE NO.			

Record on Dental Chart: Deciduous teeth - **d** (Decayed), **e** (indicated for extraction), and **f** (filled)
Permanent teeth - **D** (Decayed), **M** (Missing), and **F** (Filled)

		TOOTH CHART																
		RIGHT								LEFT								
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER					A	B	C	D	E	F	G	H	I	J				UPPER
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LOWER
		T				S	R	Q	P	O	N	M	L	K				
First Exam	Upper																	UPPER
	Lower																	LOWER
Second Exam	Upper																	UPPER
	Lower																	LOWER
Third Exam	Upper																	UPPER
	Lower																	LOWER
Fourth Exam	Upper																	UPPER
	Lower																	LOWER
Fifth Exam	Upper																	UPPER
	Lower																	LOWER

STUDENT REFERRAL

DATE	EXAMINED OR EVALUATED BY	REFERRED TO	REMARKS (if yes, next page)
1ST EXAM			Yes <input type="checkbox"/> No <input type="checkbox"/>
2ND EXAM			Yes <input type="checkbox"/> No <input type="checkbox"/>
3RD EXAM			Yes <input type="checkbox"/> No <input type="checkbox"/>
4TH EXAM			Yes <input type="checkbox"/> No <input type="checkbox"/>
5TH EXAM			Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER			Yes <input type="checkbox"/> No <input type="checkbox"/>

DENTAL FINDINGS – Check Applicable Items

[illegible][illegible]



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other: _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	* ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD ☐ DO ☐ PAC ☐ CRNP ☐

HEALTH CARE PROVIDERS: *Please photocopy immunization history from student's record – OR – insert information below.*

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

Medical ☐ Date Issued: _____ Reason: _____ Date Rescinded: _____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

