**COUNCIL ROCK SCHOOL DISTRICT**
**School Health Services Information**

Dear Parent or Guardian,

On behalf of the school nurses, I welcome you to the Council Rock School District. In order that we can provide optimum health services for your child we request your assistance by providing the following information for the school nurse. Forms can be downloaded from the website, obtained from Central Registration or the school.

**Immunizations –** Written proof of immunization must be presented **at the time of registration.** If you do not have written proof of immunizations signed by a medical provider available (i.e. a copy of your child's immunization record from their prior school or a physician's written record) your physician should be requested to complete the **Physician Immunization Form**. It is important to be aware that your child may be denied attendance unless immunizations are up to date.

**Physical Examination –** In accordance with Pennsylvania law, all children must have a physical examination upon entry to school (kindergarten or first grade) and in grades 6 and 10. **If a record of physical examination at the appropriate intervals is not included in your child's school record, a physical examination will be required upon entry to Council Rock School District.** Please return the completed **Private Physician Exam Form** to the school nurse, if indicated. *In the event of financial need, you may request that the examination be done by a school physician.*

**Dental Examination –** In accordance with Pennsylvania law, all children must have a dental examination upon entry to school (kindergarten or first grade) and in grades 3 and 7. If a record of dental examination at the appropriate intervals is not included in your child's school record, a dental examination will be required upon entry to Council Rock School District. Please return the completed **Private Dental Exam Form** the school nurse, if indicated. *In the event of financial need you may request that the examination be done by a school dentist.*

**Health History –** Please present the school with the completed **Health History Form** at the time of registration**.** If your child has a medical condition, e.g. asthma, diabetes, severe allergy or cardiac condition, please contact the school nurse to plan for your child's needs.

**Medications –** Council Rock School District's **Permission to Administer Medication Form** is required for all students receiving medication in school. This form must be completed and signed by an approved medical provider and parents. Please return the completed form with prescribed medication to the school nurse.

**School Health Record –** Your child's school health record will be requested from their previous school. You will be contacted if these records are incomplete or if further information is needed.

Please feel free to contact the school nurse if you have any question or concern about the school health program.

Sincerely,
Lynn G. Smith, R.N., B.S.
Health Services Coordinator

**COUNCIL ROCK SCHOOL DISTRICT**

## FAMILY HEALTH HISTORY

Child's Name _____ M☐ F☐ Birth Date _____

Address _____

Telephone _____ Birth Place _____

Father's Name _____ Mother's Name _____

Family Doctor _____ Telephone _____

Name of Pre-School Program _____

_____

## CHILD'S HISTORY

| **Does your child have:** | **Yes** | **No** |
|---|---|---|
| Allergies | ___ | ___ |
| If yes, explain _____ | | |
| Asthma | ___ | ___ |
| Ear Infections | ___ | ___ |
| Convulsions | ___ | ___ |
| Frequent Colds | ___ | ___ |
| Frequent Sore Throats | ___ | ___ |
| Speech Difficulties | ___ | ___ |
| Vision Problems | ___ | ___ |
| Other Concerns | ___ | ___ |
| Is your child on any medications | ___ | ___ |
| List medications _____ | | |
| _____ | | |

| **Has your child had:** | **Yes** | **Date (yr)** |
|---|---|---|
| Chickenpox | ___ | _____ |
| Head Injury/Concussion | ___ | _____ |
| Febrile Convulsions | ___ | _____ |
| Hepatitis | ___ | _____ |
| Measles, German | ___ | _____ |
| Measles, Regular | ___ | _____ |
| Mononucleosis | ___ | _____ |
| Mumps | ___ | _____ |
| Polio | ___ | _____ |
| Rheumatic Fever | ___ | _____ |
| Scarlet Fever | ___ | _____ |
| Whopping Cough | ___ | _____ |
| Other _____ | | |

If your child has a history of **Head Injury/Concussion** – Please explain:_____

_____

Did mother have measles or other serious illness during pregnancy? _____

Was oxygen administered to your child at birth? _____

Any serious illnesses or surgery? _____ If yes, what? _____

Is your child under medical treatment? _____ If yes, explain _____

State any other information which would aid the school in a better understanding of your child.

_____

### Family History

| **Is there a history of:** | **Yes** | **Relationship** |
|---|---|---|
| Allergies | ___ | _____ |
| Asthma | ___ | _____ |
| Color Deficiency (Blindness) | ___ | _____ |
| Convulsive Disorders | ___ | _____ |
| Diabetes | ___ | _____ |
| Hearing Disorders | ___ | _____ |
| Reading Disorders | ___ | _____ |
| Tuberculosis | ___ | _____ |
| Visual Disorder | ___ | _____ |
| Other | ___ | _____ |

### Child's Developmental History

Birth Weight _____

Age Walked _____

Age Talked _____

Age Toilet Trained _____

Age Stopped Bed-Wetting _____

_____ _____

*Date* *Signature of Parent/Guardian*

## COUNCIL ROCK SCHOOL DISTRICT

**Dear Physician,**
**In order to comply with Pennsylvania Immunization Law, we request that you complete this form and return it to the parent or guardian of the child named below so that they may register in our school district.**

**Student** _____ **Date of Birth** _____ **Entering Grade** _____

**IMMUNIZATIONS AND TESTS (**shading represents required Immunizations)

| **VACCINE** | *Enter Month, Day, and Year each immunization was given* **DOSES** | | | **BOOSTERS & DATES** | |
|---|---|---|---|---|---|
| Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD | 1 / / | 2 / / | 3 / / | 4 / / | |
| Polio (Circle): OPV, IPV | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| MMR 1st dose after 1 yr of age | 1 / / | 2 / / | | | |
| Measles 1st dose after 1 yr of age | 1 / / | 2 / / | | | |
| Mumps 1st dose after 1 yr of age | 1 / / | 2 / / 2nd dose of Mumps | | | |
| Rubella after 1 yr of age | 1 / / | | | | |
| Hepatitis B | 1 / / | 2 / / | 3 / / | | |
| Hepatitis A (not required) | 1 / / | 2 / / | 3 / / | | |
| HIB (not required) | 1 / / | 2 / / | 3 / / | | |
| Varicella | 1 / / | 2 / / 2nd dose of Varicella | | Varicella Disease or Lab Evidence Date: _____ | |
| Children Attending 7th Gr: Meningococcal Conjugate (MCV) _____/_____/_____ | | | | Tetanus, Diphtheria and Acellular Pertussis Tdap _____/_____/_____ | |
| Other _____/_____/_____ | | | | | |

These requirements allow for medical reasons and religious beliefs. If your child is exempt from immunizations, he/she may be removed from school during an outbreak.

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health.

☐ RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or guardian.

**FOR ATTENDANCE IN ALL GRADES:**
**Children need the following:**
- 4 doses of tetanus* **(1 dose on or after the 4th birthday)**
- 4 doses of diphtheria* **(1 dose on or after the 4th birthday)**
- 3 doses of polio
- 2 doses of measles** (MMR)
- **2 doses of mumps ** (MMR)**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- **2** doses of Varicella (chickenpox) vaccine or history of disease

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

**CHILDREN ATTENDING 7TH GRADE NEED THE FOLLOWING:**
- **1** dose of tetanus, diphtheria, accellular pertussis (**Tdap**) (if 5 years has elapsed since last tetanus immunization)
- 1 dose of meningococcal conjugate vaccine (**MCV**)

Pennsylvania's school immunization requirements can be found in 28 PA.CODE CH.23 (School Immunization)
**Contact your health care provider or 1-877 PA HEALTH for more information**

Date _____ Physician Signature _____

Physician Address _____

37(11/11) Physician Telephone _____

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

# PRIVATE DENTIST REPORT
# OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL_____ DATE _____ 20 ___

| NAME OF CHILD | AGE | SEX | GRADE | SECTION/ROOM |
|---|---|---|---|---|
| _____ Last First Middle | | ☐ M ☐ F | | |

ADDRESS

_____
No. and Street City or Post Office Borough or Township County State Zip

**REPORT OF EXAMINATION**

**TOOTH CHART**

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

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

**Council Rock School District**
**Bucks County Pennsylvania**

# PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20_____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD DATE OF BIRTH SEX

_____ _____ M F

Last First Middle

ADDRESS

_____

No. and Street City or Post Office Borough or Township County State Zip Code

## MEDICAL HISTORY
## IMMUNIZATIONS AND TESTS

| VACCINE | Enter month, day & year each immunization was given DOSES | | | BOOSTERS & DATES | | |
|---|---|---|---|---|---|---|
| Diphtheria and Tetanus (circle): DTaP, DTP, DT, TD | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / | Tdap 7th gr / / |
| Polio (circle): OPV, IPV | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / | |
| MMR 1st dose after 1 yr of age | 1 / / | 2 / / | | | | |
| Measles 1st dose after 1 yr of age | 1 / / | 2 / / | | | | |
| Mumps 1st dose after 1 yr of age | 1 / / | 2 / / | | | | |
| Rubella after 1 yr of age | 1 / / | | | | | |
| Hepatitis B | 1 / / | 2 / / | 3 / / | | | |
| Hepatitis A (not required) | 1 / / | 2 / / | 3 / / | | | |
| HIB (not required) | 1 / / | 2 / / | 3 / / | | | |
| Varicella | 1 / / | 2 / / | Varicella Disease or Lab Evidence Date: _____ | | | |
| Entering 7th grade: Meningococcal Conjugate (MCV) | | 1 / / | | | | |
| Other | 1 / / | 2 / / | 3 / / | | | |

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health.

☐ RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or guardian.

If Applicable:

| Tuberculin Tests | Date Applied | Arm | Device | Antigen | Manufacturer | Signature |
|---|---|---|---|---|---|---|
| | | | | | | |
| Date Read | Results (mm) | | | Signature | | |

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on_____ (Date)
Result of Diagnostic Studies: _____ (Date)
Preventive Anti-Tuberculosis – Chemotherapy ordered: NO YES _____ (Date)

**Significant Medical Conditions (√)**

| | Yes | No | If Yes, Explain |
|---|---|---|---|
| Allergies | ☐ | ☐ | _____ |
| Asthma | ☐ | ☐ | _____ |
| Cardiac | ☐ | ☐ | _____ |
| Chemical Dependency | ☐ | ☐ | _____ |
| Drugs | ☐ | ☐ | _____ |
| Alcohol | ☐ | ☐ | _____ |
| Diabetes Mellitus | ☐ | ☐ | _____ |
| Gastrointestinal Disorder | ☐ | ☐ | _____ |
| Hearing Disorder | ☐ | ☐ | _____ |
| Hypertension | ☐ | ☐ | _____ |
| Neuromuscular Disorder | ☐ | ☐ | _____ |
| Orthopedic Condition | ☐ | ☐ | _____ |
| Respiratory Illness | ☐ | ☐ | _____ |
| Seizure Disorder | ☐ | ☐ | _____ |
| Skin Disorder | ☐ | ☐ | _____ |
| Vision Disorder | ☐ | ☐ | _____ |
| Other (Specify) | ☐ | ☐ | _____ |

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

**Report of Physical Examination (√)**

| | Normal | Abnormal | Not Examined | Comments |
|---|---|---|---|---|
| • Height (inches) | | | | |
| • Weight (pounds) BMI | | | | |
| • Pulse ( ) | | | | |
| • Blood Pressure / | | | | |
| • Hair/Scalp | | | | |
| • Skin | | | | |
| • Eyes/Vision | | | | |
| • Ears/Hearing | | | | |
| • Nose and Throat | | | | |
| • Teeth and Gingiva | | | | |
| • Lymph Glands | | | | |
| • Heart – Murmur, etc. | | | | |
| • Lung – Adventitious Findings | | | | |
| • Abdomen | | | | |
| • Genitourinary | | | | |
| • Neuromuscular System | | | | |
| • Extremities | | | | |
| • Spine (Presence of Scoliosis) | | | | |

_____
Date of Examination

_____ _____
Signature of Examiner **Print** Name of Examiner

_____ _____
Address Telephone Number