

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** to 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	Has your child had:	Yes	Date (yr)
Allergies	___	___	Chickenpox	___	_____
If yes, explain _____			Head Injury/Concussion	___	_____
Asthma	___	___	Febrile Convulsions	___	_____
Ear Infections	___	___	Hepatitis	___	_____
Convulsions	___	___	Measles, German	___	_____
Frequent Colds	___	___	Measles, Regular	___	_____
Frequent Sore Throats	___	___	Mononucleosis	___	_____
Speech Difficulties	___	___	Mumps	___	_____
Vision Problems	___	___	Polio	___	_____
Other Concerns	___	___	Rheumatic Fever	___	_____
Is your child on any medications	___	___	Scarlet Fever	___	_____
List medications _____			Whooping 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			BOOSTERS & DATES	
	DOSES				
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
MMR 1 st dose after 1 yr of age	1 / /	2 / /			
Measles 1 st dose after 1 yr of age	1 / /	2 / /			
Mumps 1 st 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, acellular 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 _____

Physician Telephone _____

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
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last First Middle						

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

ADDRESS _____
Last First Middle

_____ 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			BOOSTERS & DATES		
	DOSES					
Diphtheria and Tetanus (circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /	Tdap 7 th gr / /
Polio (circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /	
MMR 1 st dose after 1 yr of age	1 / /	2 / /				
Measles 1 st dose after 1 yr of age	1 / /	2 / /				
Mumps 1 st 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 7 th 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

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