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
Bucks County, Pennsylvania

Health History

Former School _____ Council Rock School _____
&
Address _____ Date of Entry _____ Grade _____

Name of Child _____ M___ F___ Birthdate _____
(Last) (First) (Middle)

Address _____ Telephone _____

Father's Name _____
(Last) (First) (Middle)

Mother's Name _____
(Last) (First) (Middle)

Person with whom pupil lives _____
(Name) (Relationship)

Medical History

Has your child had:	Yes	No	Date / Age	If Yes / Explain
Chickenpox Disease? If *yes*, please add approximate date or age.	___	___	_____	_____
Any operations?	___	___	_____	_____
Any illnesses requiring hospitalizations?	___	___	_____	_____
Any broken bones?	___	___	_____	_____
Any head injuries or concussions?	___	___	_____	_____
Any dizzy spells, blackouts or loss of consciousness?	___	___	_____	_____
Any episodes of wheezing or shortness of breath?	___	___	_____	_____
Any allergies?	___	___	_____	_____
Any seizures or convulsions?	___	___	_____	_____
Any restrictions for play or physical education?	___	___	_____	_____
Is your child under treatment?	___	___	_____	_____
Is your child receiving any daily medication?	___	___	_____	_____

State any other information that will aid the school to better understand your child _____

_____

_____
Signature of Parent/Guardian *Date*

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 _____

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