COUNCIL ROCK SCHOOL DISTRICT

Dear Parent or Guardian,

DIPHTHERIA, TETANUS
three dose initial series **and**
a **fourth** dose administered **on or after the fourth birthday**
POLIO
three dose series

MEASLES, MUMPS** and RUBELLA**
first dose administered at 12 months of age or older and
a **second** dose of **measles** and **mumps** vaccine preferably administered as MMR combination
HEPATITIS B
three dose series, properly spaced
VARICELLA
Two doses of varicella vaccine, **or** history of the disease, **or** immunity confirmed by laboratory testing

If you do not currently have printed proof of immunizations, your physician should be requested to complete the attached form #37.

Pennsylvania law requires that proof of immunization must be provided **before** a child can be admitted to kindergarten or first grade in any public, private or parochial school. *At the time of registration* you must submit written proof, **signed by a physician**, of the following minimum immunizations:

In addition to the record of your child's immunizations, please complete and submit the attached family health history. If your child has a medical condition (for example - asthma requiring daily medication, diabetes, severe allergy, cardiac condition, etc.) please contact the school nurse.

All children newly enrolled in kindergarten or first grade are required to have **a physical and a dental examination.** Examinations performed by your private physician or dentist are encouraged and are acceptable when completed **no earlier than one year prior to entry to school.** We encourage all parents and guardians to utilize a physician and dentist that their child sees on a regular basis. Coordination and continuity of care is enhanced when your child's personal physician performs these examinations. In the case of financial need, the school district will arrange to have these examinations performed by the school's physician or dentist. Forms for these examinations are attached. **Completed forms should be returned to the school nurse by the opening of school.**

If you currently lack health care coverage for your children, Pennsylvania's Children's Health Insurance Program (CHIP) may be able to help. Call the toll-free helpline at 1-800-986-KIDS to find out if your children may be eligible for the CHIP program.

Thank you for your cooperation.
Lynn G. Smith
Lynn G. Smith, R.N., B.S.
Health Services Coordinator

_____
School Nurse

The following exemptions from immunizations are available:
Medical - Children need not be immunized if a physician or their designee provides a written statement that immunization may be detrimental to the child's health. When the physician determines that immunization is no longer detrimental to the child's health, the child shall be immunized.
Religious - Children need not be immunized if the parent or guardian objects, in writing, to the immunization on religious grounds, or on the basis of a strong moral or ethical conviction similar to a religious belief.

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 _____

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

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