THE SCHOOL DISTRICT OF
PHILADELPHIA

Student Emergency /Medical Information

Last Name:_____ First Name:_____ DOB: _____

School:_____ Room/Sec:_____ Grade:_____

Home Address: _____ Home phone: _____

Mother: _____ email: _____ phone: _____

Father: _____ email: _____ phone: _____

Guardian: _____ email: _____ phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child **Phone**

1._____

2._____

Childs Doctor/Clinic: _____ Phone:_____

Medical Insurance: MA___ CHIP____ Private_____

Insurance company name: _____ Policy Number_____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	**YES**	**NO**
Ibuprofen (Advil, Motrin)	**YES**	**NO**

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _____

_____

Other Health Problems: _____

_____

_____

Does your child take medication? ____NO ____YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities. I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature _____ **Date**_____

Revised S-865 (06/2018)

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Date Issued: [Date]	Student ID#:

Name of Student:	Date of Birth:	Grade:
Name of School:	Room/Section/Book	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature_____Date_____

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

(Please attach complete immunization record including serology results if available)

- Allergies_____
- Date of last PPD_____Result_____mm

Does this student have health insurance? _____ Yes _____ No Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L _____ With Glasses: R _____ L _____
2. Audiometric Screening: R _____ L _____ 3. BP _____
4. Height _____ inches/cm Weight _____lb./kg BMI percentile _____
5. Scoliosis Screening: _____ Normal _____Abnormal _____ Referred _____ No Referral
6. Activity Recommendation: _____ Full Physical Activity _____Restricted Physical Activity
   (Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions:_____
7. List all medications currently being taken:
   Medications:_____Reason:_____
8. List ALL problems by history or examination: Circle status of problem
   1._____ Under Care Care Complete Referred
   2._____ Under Care Care Complete Referred
   3._____ Under Care Care Complete Referred
   _____ No Problems Identified

Comments/follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

MEH-1 (Rev. 2/17)

THE SCHOOL DISTRICT OF PHILADELPHIA

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments / Follow-up Treatment / Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

_____
Certified School Nurse/Practitioner

_____
School

_____
School Address

_____
Phone Number

City of Philadelphia
DEPARTMENT OF PUBLIC HEALTH
Division of Disease Control

Philadelphia Immunization Requirements for School Entry (2018/2019)

Vaccines are required on the first day of school

A child must have at least one dose of all vaccinations, or risk exclusion.
A child may have a documented medical, religious, or philosophical exemption from these vaccinations.
Even if exempt, a child may be excluded from school during an outbreak of vaccine-preventable disease.

If a child doesn't have all required doses of a vaccine, she/he must <u>within the first 5 days of school:</u>

Receive the next dose, if medically appropriate.
Have a parent/guardian provide a medical plan, if the next dose isn't the final dose of the series.
Have a parent/guardian provide a medical plan, if the next dose is not medically appropriate.

Required on the first day of school:

All Grades	Doses	Notes
Tetanus, diphtheria, pertussis (DTP/Dtap/DT/Td, or Tdap)	4*	1 dose on or after age 4 years
Polio (OPV/IPV)	4	4th dose on or after age 4 years, at least 6 months after previous dose**
Measles, mumps, rubella (MMR/MMRV)	2	On or after age 1 year
Hepatitis B (HBV)	3	
Chickenpox (Varicella/MMRV)	2	On or after age 1 year***

7th grade	Doses	Notes
Meningococcal conjugate vaccine (MCV4)	1	On or after age 2 years
Tetanus, diphtheria, pertussis (Tdap)	1	On or after age 7 years

12th grade	Doses	Notes
Meningococcal conjugate vaccine (MCV4)	2	If 1st dose given at age 16 years or older, only 1 dose is needed to enter 12th grade

* *Only 3 doses of Td-containing vaccine are necessary if series started on or after age 7 yrs and at least one dose is Tdap*

** *A 4th dose is not necessary if 3rd dose was given at age 4 years or older and at least 6 months after the previous dose*

*** *Or documentation of immunity by lab test or written statement from parent, guardian, or physician*

Reference: The Pennsylvania Code – Subchapter C. *IMMUNIZATION* §23.81, and from the Philadelphia Board of Health *Regulations Governing the Health of Newborns, Children and Adolescents*, published 2017.

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

PHYSICAL EDUCATION MEDICAL EXEMPTION / PROGRAM MODIFICATION

To the Parent/Guardian:

Participation in our Physical Education Program is required for all students. Modifications are available for students who are unable to participate in all parts of the program. It is your responsibility to contact the school nurse if the student requires a modified program. In cases of temporary restriction, the student is still required to report to his/her regularly scheduled physical education class and must continue to take health education classes. This form is to be completed ***every school year*** *by your physician and returned to the school nurse. The School Nurse will forward a copy to the school Department of Physical and Health Education.*

Physician: The Pennsylvania Department of Education requires ALL students to participate in a planned program of physical education at EVERY GRADE LEVEL..

STUDENT'S NAME - LAST FIRST M.I.	BIRTH DATE - MO/DAY/YR	PID#
NAME OF SCHOOL	GRADE	ROOM
SCHOOL NURSE	TELEPHONE	DATE ISSUED

■ *COMPLETED BY CARE PROVIDER*

Our patient has requested an excuse from the regular physical education program based on the health condition listed below:

Diagnosis: _____

1. CHECK DEGREE OF ACTIVITY PERMITTED: 2. CHECK ANYTHING WITHIN THAT CATEGORY WHICH IS NOT PERMITTED.

☐ VIGOROUS		☐ MODERATE (CALISTHENICS & GENERAL EXERCISES REQUIRING MODERATE RUNNING AND MUSCULAR EFFORT)		☐ MILD (I.E. WALKING OR MOVEMENT OF ARMS, NECK & TRUNK)	
☐ RUNNING	☐ SOCCER	☐ YOGA	☐ MEDICINE BALL	☐ WALKING - INDOOR	☐ TABLE TENNIS
☐ JUMPING	☐ BASKETBALL	☐ DANCE	☐ LOW ORGANIZED GAMES	☐ OUTDOOR	☐ SHUFFLEBOARD
☐ AEROBICS	☐ TRACK & FIELD	☐ SOFTBALL	☐ BADMINTON	☐ ARCHERY	☐ BOWLING
☐ YOGA	☐ FLAG FOOTBALL	☐ TENNIS	☐ KICKBALL	☐ YOGA	☐ BALL DRILLS
☐ DANCE	☐ SPEEDBALL	☐ VOLLEYBALL	☐ STUNTS	☐ BADMINTON	☐ HAND APPARATUS DRILLS
☐ TENNIS	☐ GYMNASTICS	☐ WEIGHT TRAINING	☐ TETHERBALL	☐ GOLF	☐ THERAPEUTIC EXERCISES
☐ HOCKEY (FIELD)		☐ THERAPEUTIC EXERCISES	☐ ROLLER SKATING	☐ DANCE	☐ LOW ORGANIZED GAMES
☐ HOCKEY (FLOOR)		☐ JOGGING	☐ HANDBALL GAMES	☐ QUOITS/HORSESHOES	
		☐ ROPE DRILL			

☐ RESTRICTION REQUESTED FOR _____ WEEKS DATE OF EXAMINATION_____

☐ MODIFICATION REQUESTED FOR _____ WEEKS

Comments:

Signature of Care Provider (REQUIRED)	Telephone	Care Provider office stamp (REQUIRED)
Address	Date Signed	