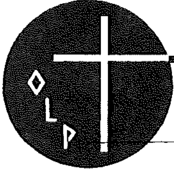
Our Lady of Peace School



410 NORTH ABINGTON ROAD
TELEPHONE: (570) 587-4152
E-MAIL: OLPEACESCHOOL@COMCAST.NET

CLARKS GREEN, PENNSYLVANIA 18411
FAX: (570) 586-5393
WEBSITE: WWW.OLPCLARKSSUMMIT.COM

Dear Parent:

Welcome to Abington Heights School District. Enclosed you will find the necessary medical forms needed for your child.

The forms that **MUST BE SUBMITTED DURING REGISTRATION ARE:**

1. **Emergency Card** - giving permission to treat your child with first aid, transport to a hospital and send your child home with someone other than you in the event of an emergency or illness.
2. **Health Data** - to give any medical information you would like us to know about your child.
3. **A Doctor's Copy of your Child's Immunization** – immunizations are state mandated to attend school in Pennsylvania. **Your child will not be allowed to attend school without the required immunizations or a medical, religious or moral exemption.**

   A **DT** immunization is needed *on or only four days before your child's fourth birthday.*

   Varicella and Measles, Mumps and Rubella (MMR), should not have been given before the age of one year old. Please check your child's record and speak to your doctor as you may be required to repeat these immunizations according to the Pennsylvania Department of Health.

A physical and dental exam form is also included. A physical and dental exam is needed for those children entering school for the first time. A dental exam is required again in third grade. Please be aware that Abington Heights Board Policy requires that the **examinations must be completed and returned by May 1st** of the required school year. After that date, **your student will be excluded from school** until the physical/dental exam form is received by the school nurse. A free physical/dental exam is offered in the spring. Information about this exam will be sent home.

I look forward to working with you and your child in the up-coming school year.

Sincerely,

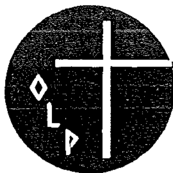
Christina Bohn

Christina Bohn, RN, MSN

Certified School Nurse

South Abington Elementary School
570-585-2104
Newton-Ransom Elementary School
570-585-8304

Our Lady of Peace School



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To: Parent or Guardian
From: School Health Services

Information provided on this form will enable school personnel to deal most effectively with your child's health problem(s) and allow him/her to receive the maximum benefits from his/her educational experience.

School: ______________________ Grade: ______ Date: __________

Student's Name: ______________________ Birth Date: ________ Male / Female

Address: ____

Father's Name: ____
Last First

Mother's Name: ____
Last First

Guardian (if other than parent): ______________________________

Does your child have health insurance coverage? Yes / No

1. Has your child had Chicken Pox (Disease)? Yes / No Date: __________
2. Has your child ever had an allergic reaction to any medication? Yes / No
   If YES, Name of medication: ______________________________
3. Is your child allergic to BEE / WASP STINGS? Yes / No
   Please describe reaction: ______________________________
4. Is your child allergic to specific foods? Yes / No
   If YES, type of food: ______________________________
   Please describe reaction: ______________________________
5. Does your child have any difficulty with hearing? Yes / No
6. Does your child have any difficulty with vision? Yes / No
7. Is there anything more about your child's health that you think is important for the school to know? Yes / No Please indicate the nature of the condition:
   ____
   ____

8. May the information in questions 3 through 7 be shared with other school personnel, as necessary for the health of your child? Yes / No

Date: __________ Signature of Parent/Guardian: ______________________

H514.027 (08/2011)

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 Last First Middle	AGE	SEX ☐ M ☐ F	GRADE	SECTION/ROOM

ADDRESS

No. and Street | City or Post Office | Borough/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 ☐

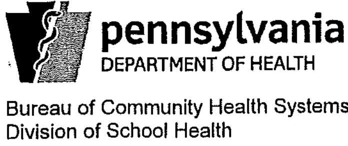
Treatment Completed Yes ☐ No ☐

____
Date of Dental Examination

____
Signature of Dental Examiner

____
Print Name of Dental Examiner

____
Address



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name ______________________ Today's date______________

Date of birth ______________ Age at time of exam__________ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

____

____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student...*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other________		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student...*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:________		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student...*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student...*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? ______ How many periods has she had in the last 12 months? ______ Date of last period: __________		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: ______________ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student...*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other______________		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other__________		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student__________________________ Date__________

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:__________				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					