Grade 12
School Year 2024 - 2025

Check-List

- ☐ **Medical Diagnosis or Allergy**
  - ☐ Physician Verification form
  - ☐ Medication Administration form

- ☐ **Immunization Record Update**
  to include:
  - ☐ Immunization required for entry into Grade 12
    MCV #2

FRAZIER SCHOOL DISTRICT
142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390 FAX: (724) 736-0688

Dear Parent/Guardian,

The PA Department of Health has determined that a Pennsylvania licensed health care provider (physician, physician assistant, or certified registered nurse practitioner) or medical specialist must verify any chronic medical diagnosis of our students.

If your child has a current, active medical diagnosis (ie: asthma, life-threatening allergy, diabetes, seizure, etc.), please contact their primary care physician and make arrangements to have the following form completed. Once received, we will verify our school health records and notify your child's teachers. This signed form will remain in effect for 5 academic years unless we are otherwise notified by you.

Also included in this correspondence is a 'Permission to Administer Medication' form. A completed form is required for ALL medication taken during school hours. This includes prescription, over-the-counter, cough drops, lotions, sunscreen, etc. All medication orders must be renewed for each school year (July1 to June 30).

Thank you for your cooperation.

Elisa DeLucia, RN, BSN, CSN
Frazier School Nurse

FRAZIER SCHOOL DISTRICT
142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390 FAX: (724) 736-0688

PHYSICIAN DIAGNOSIS VERIFICATION FORM

Child's Name:_____ Date of Birth:_____

Parent/Guardian:_____

Parent/Family Phone Number:_____

Address:_____

City, State, Zip_____

Diagnosis:_____

Date of Diagnosis_____

Brief Recommendations:

_____

Prognosis: (Please indicate whether you consider the condition to be life-threatening for this patient)

_____

Physician Name: _____

Physician Signature: _____ Date:_____

This form must be MAILED or EMAILED from the physician directly to :

edelucia@fraziersd.org
Frazier School District
Office of the School Nurse
142 Constitution Street
Perryopolis, PA 15473

FRAZIER SCHOOL DISTRICT
142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390 FAX: (724) 736-0688

PERMISSION TO ADMINISTER MEDICATION

This is to certify that _____, _____
(Name of Student) (Grade)
must receive the following medication during school hours:

*Diagnosis:_____
*Name of Medication:_____
*Dose: _____
*Route: _____
*Frequency and Times: _____
*Duration of Order: _____
*Possible Side Effects:_____

* This student is capable of self-administration [ ] Yes [ ] No
* Inhaler [ ]
* Epinephrine Auto-Injector [ ]

I do hereby release, discharge and hold harmless the Frazier School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to this child should a reaction develop from the medication. Frazier School District bears no responsibility for ensuring that self-administered medication is taken.

*ALL medication is to be provided by the parent/guardian and given to the School Nurse in the original, labeled pharmacy or manufacturer's container.

Physician Signature: _____
Date: _____
Name of Prescribing Physician:_____
Address:_____
Telephone Number: _____

Parent/Guardian Signature: _____
Date: _____
Name of Parent/Guardian:_____
Address:_____
Telephone Number: _____

FRAZIER SCHOOL DISTRICT
142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390 FAX: (724) 736-0688

Dear Parent/Guardian,

According to the PA Department of Health, **ALL** students must be fully immunized by the **FIRST DAY OF SCHOOL** or they will be recommended for **EXCLUSION** from school. Your child will need the following:

GRADE 12....

Second dose of meningococcal conjugate vaccine (MCV #2) for entry into 12th grade.

Please make all appointments BEFORE the start of the school year, so that your child is in full compliance on the first day of school. Please email, mail, or drop off a copy of all up-dated records as soon as possible.

*A student may still obtain a medical, religious or philosophical/strong moral or ethical conviction exemption from meeting the immunization requirements.
https://www.washjeff.edu/files/exemption-to-immunization-law/

Thank you.
Have a great summer!
Elisa M. DeLucia RN, BSN, CSN
Frazier School Nurse

Immunization Card Front

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Name _____ Birthdate _____

Address _____ Parent or guardian _____

_____ Telephone _____

Race/ethnicity: ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native

Hispanic origin: ☐ Yes ☐ No

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date		Titer
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

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#2

pennsylvania
DEPARTMENT OF HEALTH

Statement of Exemption to Immunization Law

Commonwealth of Pennsylvania

Name _____ **Date of Birth** _____

Address _____

Phone _____ **Grade** _____

☐ **Medical Exemption**[(a)] The physical condition of the above named child is such that immunizations would endanger life or health.

Other Comment:_____

Physician Signature: _____ Date: _____

☐ **Religious Exemption**[(b)] (Includes a strong moral or ethical conviction similar to a religious belief.)

Parent or guardian of the above name child adheres to a religious belief whose teachings are opposed to such immunizations OR holds a strong moral or ethical conviction similar to a religious belief that is opposed to such immunizations.

Other Comments/Explanation: _____

Signature Parent/Guardian: _____ Date: _____

PA 28§ 23.84. Exemption for immunization.

(a) *Medical exemption.* Children need not be immunized if a physician or designee provides a written statement that immunization may be detrimental to the health of the child. When the physician determines that immunization is no longer detrimental to the health of the child, the child shall be immunized according to this subchapter.

(b) *Religious exemption.* Children need not be immunized if the parent, guardian or emancipated child 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.