Grade 3
School Year 2024 - 2025

Check-List

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

- ☐ **Dental Exam** form
  - ☐ Signed by Dentist

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,

Pennsylvania law requires all students in **Grade 3** to have a **dental exam**. Please have your child's family dentist complete the Private Dentist Report form (found at www.frazierschooldistrict.org under Student/Parent Resources, or you may use the attached form) and return it to the office of your child's school before the beginning of the 2024-2025 school year. This will be placed in your child's health record and will serve as documentation for the school year.

Or, if you prefer, your child can be scheduled to see our school dentist during the school year. Our school dentist will then be responsible for completing the necessary documentation.

Any student without a Private Dentist Report at the time of school dental exams, will be scheduled to see the school dentist.

Thank you for your time and cooperation.
Have a great summer!

Sincerely,
Elisa DeLucia, RN, BSN, CSN
Frazier School Nurse

H514.027 (08/2011-under review)

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/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