

## Kindergarten

### Check-List

**Medical Diagnosis or Allergy**

- Physician Verification form
- Medication Administration form

**Physical Exam** form

to include:

- Vision screening results
- Hearing screening results
- Signed by Physician

**Immunization** Record

to include:

- Additional immunizations beyond Pre-K requirements

OR

Immunization Exemption 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 (July 1 to June 30).

Thank you for your cooperation.

Elisa DeLucia, RN, BSN, CSN  
Frazier School Nurse



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](mailto:edelucia@fraziersd.org)  
Frazier School District  
Office of the School Nurse  
142 Constitution Street  
Perryopolis, PA 15473



**RAZIER 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: \_\_\_\_\_



## RAZIER SCHOOL DISTRICT

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142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390

FAX: (724) 736-0688

Dear Parent/Guardian,

Pennsylvania law requires all students in **Kindergarten** to have a **physical exam**. Please have your child's family physician complete the Private Physician Report form (found at [www.frazierschooldistrict.org](http://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 upcoming 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 physician during the school year. Our school physician will then be responsible for completing the necessary documentation.

Any student without a Private Physician's Report at the time of school physicals, will be scheduled to see the school physician.

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

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



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: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	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: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	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: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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 \_\_\_\_\_

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes  No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: ( / )				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes  No

Physical exam performed at: Personal Health Care Provider's Office  School  Date of exam \_\_\_\_\_ 20\_\_\_\_

Print name of examiner \_\_\_\_\_

Print examiner's office address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of examiner \_\_\_\_\_ MD  DO  PAC  CRNP

**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 <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	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
<b>Other Vaccines: (Type and Date)</b>					



# 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	Enter month, day, and year when immunization doses listed below were given.												
Circle appropriate item	1	2	3	4	5	6	7	8	9	10	11	12	Other
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdapp)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Titer
Varicella (vaccine or disease)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Titer
Meningococcal (MCV)	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	
Other	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /	11 / /	12 / /	Mumps disease diagnosed by a physician: Date

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# Statement of Exemption to Immunization Law Commonwealth of Pennsylvania

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Check Present Grade:

- PreK  K  1  2  3  4  5  6  7  8  9  10  11  12
- Sp.Ed.

Parent/Guardian: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

**Medical Exemption**<sup>(a)</sup> The physical condition of the above named child is such that immunizations would endanger life or health.

Other Comment: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Religious Exemption**<sup>(b)</sup> (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: \_\_\_\_\_

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.



## RAZIER SCHOOL DISTRICT

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142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390

FAX: (724) 736-0688

Dear Parent/Guardian,

Pennsylvania law requires all students in **Kindergarten** to have a **dental exam**. Please have your child's family dentist complete the Private Dentist Report form (found at [www.frazierschooldistrict.org](http://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 upcoming 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

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		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

No. and Street      City or Post Office      Borough/Township      County      State      Zip

**REPORT OF EXAMINATION**

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	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