

Grade 12

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 (July 1 to June 30).

Thank you for your cooperation.

Elisa DeLucia, RN, BSN, CSN  
Frazier School Nurse

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

# 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

HS02.320 Rev. 03/2017 Page 1

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

Enter month, day, and year when immunization doses listed below were given.

VACCINE	1	2	3	4	5	6	7	8	9	10	11	12	Other
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								
Polio (OPV or IPV)	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								
Hepatitis B	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								
Measles - mumps - rubella (MMR)	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								
Varicella (vaccine or disease)	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								
Meningococcal (MCV)	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								
Other	1 / 1 / 1	2 / 1 / 1	3 / 1 / 1	4 / 1 / 1	5 / 1 / 1								

HS02.320 Rev. 03/17



\* #2

# Statement of Exemption to Immunization Law

## Commonwealth of Pennsylvania

---

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Grade \_\_\_\_\_

---

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

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.