

Grade 11

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

May want 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
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: _____



RAZIER SCHOOL DISTRICT

142 CONSTITUTION STREET, PERRYOPOLIS, PA 15473-1390

FAX: (724) 736-0688

Dear Parent/Guardian,

Pennsylvania law requires all students in **Grade 11** to have a **physical exam**. Please have your child's family physician complete the Private Physician 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 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 |
| Other Vaccines: (Type and Date) | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

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 |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------|--------|--------|--|
| Circle appropriate item 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 (Tdap) | 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 _____

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.