Grade 7
School Year 2024 - 2025

Check-List

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

- ☐ **Immunization** Record Update
  to include:
  - ☐ Immunizations required for entry into Grade 7
    MCV and tdap

  OR
- ☐ Immunization Exemption form

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

RAZIER 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

RAZIER 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

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: _____________________________________

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. You child will need the following:

GRADE 7

One dose of meningococcal conjugate vaccine (MCV) for entry into 7th grade

One dose of tetanus, diphtheria, acellular pertussis (Tdap) for entry into 7th grade 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.

Elisa M. DeLucia RN, BSN, CSN
Frazier School Nurse4

Immunization Card Front

H502.320 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					
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		

H502.320 Rev. 03/17

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.

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

Dear Parent/Guardian,

Pennsylvania law requires all students in **Grade 7** 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