EASTERN LANCASTER COUNTY SCHOOL DISTRICT
New Holland, PA 17557

Dear Parent/Guardian,

The following information is needed to adequately begin your child's school health record, which will be maintained throughout his/her school years by a certified school nurse.

The following must be returned by: August 1

__X__ The Pupil Check-In Form/Registration Form ***- submitted via application***
_____ Health Inventory – Both sides completed by parent
__X__ A **copy** of the Immunization Record ***- submitted via application***

Pennsylvania State Law requires the following immunizations in order to attend School:

For school entry: ALL students grades K-12
-4 DPT (Diphtheria, Tetanus, Pertussis): 1 dose administered on or after the 4th birthday
- 4 Polio: 1 dose administered on or after the 4th birthday & at least 6 months after previous dose
- 2 MMR (Measles, Mumps, Rubella): first dose administered after 12 months of age
- 3 Hepatitis B: Dose 2 must be a minimum of 28 days after the 1st dose
Dose 3 must be a minimum of 2 months after the 2nd dose and after age 6 month
- 2 Varicella: the first dose administered after 12 months of age; or date or age of chicken pox illness

Students entering grades 7 through 11
- 1 Tdap/Td
- 1 MCV (meningococcal) First dose given 11-15 years of age

Students entering grade 12
- 2 MCV (meningococcal) If last dose was given at 16 years of age or older only one dose is required.

The following two exam forms must be returned by or on the first day of school.

Required at initial school entry, grade 6 & grade 11

_____ Physical Exam - You may choose to have a Private Physician's Report completed by your family doctor and returned to the school nurse by the first day of school. If you choose not to have the physical exam completed by your family physician a school exam will be done by the school doctor.

Required at initial school entry, grade 3, & grade 7

_____ Dental Exam - You may choose to have the Family Dentist Report completed by your family dentist and returned to the school nurse by the first day of school. If you choose not to have the dental exam completed by your family dentist a school exam will be done by the school dentist.

Sincerely,

Your School Nurse

SCHOOL VACCINATION REQUIREMENTS
FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*

ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.

pennsylvania
DEPARTMENT OF HEALTH

From Your School Nurse:

GUIDELINES FOR KEEPING YOUR CHILD HOME FROM SCHOOL

What do you do when your child complains of not feeling well? A decision must be made to send your child to school or to keep your child at home. Here are some guidelines (not medical advice) to help you make the decision.

FEVER

No child with a fever over 100° should be sent to school. Do not allow the child to return to school until he/she has been **free of fever for 24 hours without the aid of fever reducing medication.**

COUGH/COLD

The common cold presents the biggest problem for parents. Usually a cold is not a reason to stay home. However, a child with a hacking cough and a feeling of congestion and achiness belongs home in bed even if he/she does not have a fever. The cough will hang around awhile. He/she does not need to stay home for the duration of the whole cold.

SORE THROAT

If your child complains of a sore throat and has no other symptoms, he/she may go to school. If white patches or fever are present, keep the child home and call your doctor.

RASH

This could be a sign of many things. It could be the start of many childhood illnesses such as Roseola, 5th Disease, etc., or it could be an allergic reaction or poison ivy. If you don't know the cause, do not send the child to school until your doctor says it is safe to do so.

STOMACH ACHE/VOMITING/DIARRHEA

If a stomachache is persistent and is limiting a child's ability to function, consult your doctor. If a child is vomiting, he should be at home until he/she can keep food down. A child with diarrhea should stay home.

EARACHE

Children with an earache should be seen by a doctor.

HEADACHE

If the complaint is just a headache, the child can usually go to school.

PINK EYE/RINGWORM/IMPETIGO/HEADLICE

School nurses are guided by State Regulations for the exclusion of students showing signs of communicable diseases.

- Students with pink eye must stay home for 24 hours **after they are started on appropriate medicine**.
- Students with ringworm or impetigo may return to school if they bring a release form from the family doctor saying they may return.
- Children with head lice are excluded from school until treated. After treatment, they are to be brought back to school by a parent/guardian. The nurse will check the child to see if they may return to school

If you have questions, please feel free to call the school nurse during school hours.

Eastern Lancaster County School District - Student Health Inventory

(to be completed by parent/guardian)

The information requested on this health profile will become a part of your child's confidential school health record.

Student's Full Name	Birth Date	Grade	Today's Date

Immunizations: Attach a copy of the student's immunization record or a doctor verified immunization record.

INDICATE IF A STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING: If your child has a condition that requires medication or treatment at school, contact the School Nurse to obtain the correct required forms.

Health Condition	No	Yes	
ADD/ADHD	☐	☐	Medication taken at home: Medication required at school:
Allergies to Medications	☐	☐	List:
Allergies to Food	☐	☐	List Food(s): _____ Describe the reaction _____ Does your child require Benadryl? ☐ No ☐ Yes EpiPen? ☐ No ☐ Yes
Allergy to Bee Stings	☐	☐	Describe the reaction _____ Does your child require Benadryl? ☐ No ☐ Yes EpiPen? ☐ No ☐ Yes
Allergies (other)	☐	☐	List:
Asthma	☐	☐	Triggers/symptoms _____ Medication taken at home: Medication required at school:
Blood Disorder	☐	☐	Specify: Treatment:
Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
Bowel/Digestive/Eating Issues	☐	☐	Specify:
Cancer	☐	☐	Specify: Treatment:
Concussion/Head Trauma	☐	☐	Specify: Date(s):
Congenital abnormality/ Birth defect	☐	☐	
Diabetes	☐	☐	☐Type 1 (Insulin Dependent) ☐Type 2 List medications:
Eye or Vision Problems	☐	☐	Specify: Preferential seating: ☐ No ☐ Yes
Hearing Loss	☐	☐	Specify: Preferential seating: ☐ No ☐ Yes
Heart Condition	☐	☐	Specify:
Kidney/Bladder problem	☐	☐	Specify:
Migraine Headaches (Diagnosed)	☐	☐	Triggers: Treatment:
Mental Health (Emotional, Behavioral, etc.)	☐	☐	Specify: Treatment/Medication:
Seizure Disorder	☐	☐	Type of seizure: List medications:
Other issues / Recent surgery	☐	☐	Specify: Date(s):

DISPENSING OF MEDICATIONS: **SECONDARY ONLY**	The school nurse of Eastern Lancaster County School District has standing orders signed by the school physician that allow the administration of certain medications to students with parental consent. These medications include: Tylenol, antacid chewable tablets, throat lozenges and cough syrup. If your child is not allergic to the medications, may the school nurse or designated personnel administer these medications to your child if illness/symptoms warrant?	☐ Yes ☐ No	Initials

- Over-

Tuberculosis Exposure Assessment Has your child had any contact with an adult with infectious tuberculosis?	☐ No	☐ Yes
Are you or your child foreign born or does anyone in your family travel outside the U.S.? Regions that are especially at high risk are Latin America, Mexico, Philippines, Caribbean Islands, Asia, and Africa.	☐ No	☐ Yes
Does your child have any of the following medical risk factors: Hodgkin's disease, lymphoma, diabetes, chronic renal failure, or malnutrition?	☐ No	☐ Yes
Does your child have an immunosuppressive condition such as HIV infection or has your child been exposed to individuals with HIV infection?	☐ No	☐ Yes
Is your child frequently exposed to adults in any of the following groups: Residents of nursing homes, migrant farm workers, IV drug users, homeless individuals, and incarcerated adolescents or adults?	☐ No	☐ Yes

Medical examinations are required on original entry (Kindergarten or Grade 1), Grades 6 and 11, and any other grade if moving in from out of state. You may choose to have these exams done by your family physician or it will be done at school by the school physician.

☐ School Physician
OR
☐ Name of Family Physician _____ Phone Number: _____

Date of most Recent Physical exam: _____ Parent Signature: _____

Dental examinations are required on original entry (Kindergarten or Grade 1), Grades 3 and 7, and any other grade if moving in from out of state. You may choose to have these exams done by your family dentist or it will be done at school by the school dentist.

☐ School Dentist
OR
☐ Name of Family Dentist: _____ Phone Number: _____

Date of most Recent Dental exam: _____ Parent Signature: _____

Preferred Hospital – in case of emergency, your child will be taken to the nearest hospital or physician
Hospital Name _____

- In the event I cannot be reached in an emergency, I hereby give my permission to the attending physician and/or hospital staff to give emergency treatment to my child. ☐ Yes ☐ No Initials _____
- Please contact the school nurse if there any changes in your child's health status.
- All information may be shared in a confidential manner with appropriate school personnel as needed in order to provide for your child's educational, health and safety needs.

_____ _____ _____
PARENT/GUARDIAN SIGNATURE *PRINTED NAME* *DATE*

pennsylvania
DEPARTMENT OF HEALTH

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: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ***Has the student…***	**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: ***Has the student...***	**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: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ 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: ***Has the student...***	**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: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**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? ☐ Yes ☐ 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: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**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: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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 PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**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 ☐				
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 ☐**

Eastern Lancaster County School District
Health Services

Grade: _____

Dear Parent or Guardian of: _____ Homeroom: _____

The School Health Law requires dental examinations for children upon initial entry **(K or 1) and in grades 3 and 7.** These grades were selected because they represent critical periods of growth and development in a child's life.

We are recommending that these examinations be done by your family dentist, since he/she can best evaluate your child's dental health and assist you in obtaining necessary treatment and corrections.

It is important that the school have a record of a child's health status. This knowledge enables the school staff to help children achieve maximum benefits of their educational opportunities.

Any exam dated one year prior to the first day of the required year will satisfy this requirement.

EASTERN LANCASTER COUNTY SCHOOL DISTRICT
HEALTH SERVICES

FAMILY DENTIST REPORT

NAME OF CHILD: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE: _____ HR: _____ GENDER: _____

The above named child last visited my office on _____ (give date).

At that time all necessary dental corrections have been made: Yes ☐ No ☐

This child is currently under treatment: Yes ☐ No ☐

Check the appropriate box/boxes:

- ☐ Fillings of primary teeth
- ☐ Extractions of primary teeth
- ☐ Fillings of permanent Teeth
- ☐ Extractions of permanent teeth
- ☐ Diseases of the supporting tissues
- ☐ Gross malocclusion which is producing a facial deformity or interfering with functio
- ☐ Cleft palate and or cleft lip; other congenital malformation _____
- ☐ Prosthetic replacements for lost or missing teeth

Signature: _____ D.D.S./D.M.D. _____

Printed Name: _____

Phone: _____

Address or Stamp with address