THE SCHOOL DISTRICT OF PHILADELPHIA

STUDENT MEDICAL HISTORY

Name of Student	Date of Birth	Date
Name of School	**Room/Book/Section**	**Grade**

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by_____

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply asneeded regarding my child's care.

Parent/Guardian Signature_____***Date***_____

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Do you have health insurance? ___ Yes ___ No What is the name of your insurance?_____
2. Where do you take your child for checkups?_____ Phone:_____ Fax: _____
3. Date of child's last physical examination?_____
4. Where do you take your child for dental care? _____ Phone:_____ Fax: _____
5. Date of child's last dental examination?_____
6. Does your child take any medicine now? ___ Yes ___ No, If yes, list below:
   - Medicine: _____ How often _____ For what _____
   - Medicine: _____ How often _____ For what _____
   - Medicine: _____ How often _____ For what _____
7. Is your child allergic to anything? ___ Yes ___ No, If yes, to what_____
8. Does your child have any activity restrictions? ___ Yes ___ No, If yes, explain_____

PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD

__ Asthma	__ Dental	__ High Blood Pressure	__ Physical Disability
__ Anemia	__ Diabetes	__ Hospitalized (Surgery)	__ Premature Birth (Under 5 Lbs)
__ Arthritis	__ Drug/Alcohol	__ Learning Problem	__ Seizures
__ Behavior/Emotional	__ Eczema	__ Lung Disease	__ Speech Difficulty
__ Blood Disorders	__ Frequent Colds	__ Lead Poisoning	__ Tuberculosis
__ Cancer	__ Hearing Difficulty	__ Meningitis	__ Vision Problems
__ Chicken Pox at age___	__ Heart	__ Muscle/Bone/Joint	__ Urinating/Kidney Problem

*Additional comments:*_____

_____

_____

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School	Room/Section/Book	Date Issued	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature_____ Date_____

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

■ Allergies _____ ■ Date of last PPD_____ Result_____mm

Does this student have health insurance? ___ Yes ___ No Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____
2. Audiometric Screening: R_____ L_____ 3. BP_____
4. Height _____inches / cm Weight _____lb. / kg BMI percentile _____
5. Scoliosis Screening: ____ Normal ____ Abnormal ____ Referred ____ No Referral
6. Activity Recommendation: ____ Full Physical Activity ____ Restricted Physical Activity
   (Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions: _____
7. List all medications currently being taken:
   Medication:_____ Reason:_____
8. List ALL problems by history or examination: Circle status of problem
   1. _____ Under Care Care Complete Referred
   2. _____ Under Care Care Complete Referred
   3. _____ Under Care Care Complete Referred

   ____ No Problems Identified

Comments / follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication / treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT	ADDRESS/ZIP	ROOM/BOOK NO.

DATE OF BIRTH	SCHOOL/ORG.#	REGIONAL OFFICE	PID

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDICATION/EQUIPMENT/TREATMENT:	DOSE:

TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:

DATE BEGIN:	DATE END:

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS: _____

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN: _____

IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES ☐ NO ☐

IF YES, DESCRIBE: _____

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS: _____

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES ☐ NO ☐

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE

ADDRESS	EMERGENCY NUMBER

SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

To The Principal

- I authorize selected school personnel to administer the indicated medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.
- Medication is to be administered by the Certified School Nurse. In the absence of the Certified School Nurse, it may be administered by the Principal or his/her designees.
  Certified School Nurse will provide instruction for administration of medication or use of equipment to the Principal or his/her designees.
- My child may self-administer medication/equipment as determined appropriate by the school nurse.
- I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply, as needed, regarding this medication/ equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE

- I have assessed this student and he/she has demonstrated competency and may self administer this medication/treatment (__) yes (__) no
- The administration of this medication/treatment was approved on: _____ DATE

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

TO THE PHYSICIAN:
Your patient has requested that medication or equipment be utilized in school. Ideally, the administration of medication or utilization of equipment should take place at home. However, for students who require medication/treatment during the school day in order to function in the classroom, School District Policy does permit selected school staff to administer medication. In some cases, students may self-administer their medication.

School District Policy also permits the use of equipment/machinery in those instances where similar equipment is kept by the child's family at home, and such equipment/machinery is necessary in order to enable the student to function in the classroom. Instruction for use and precautions should be spelled out in detail.

(IF YOUR PATIENT'S MEDICATION OR TREATMENT SCHEDULE CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE REVERSE SIDE - A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT).

When the medication/treatment prescribed exceeds or differs from that approved by the FDA or recommended by the manufacturer, you and the child's parent will be required to submit written detailed information to the School Nurse. This must include a list of side effects and confirmation that all side-effects have been explained to and are understood by the parent. Any particularly dangerous conditions being experienced by the child should be spelled out in detail, with the procedure to follow should a reaction occur.

Please fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment.

Thank you.

School Health Services

DEAR PARENT/GUARDIAN:

Some children need the administration of medication or special equipment in order to function in the classroom. Ideally, this should take place at home. If your child's medication/equipment schedule cannot be altered so that everything can be administered at home, you can request that they be given in school by seeing the school nurse or principal.
When the medication/treatment prescribed for your child exceeds or differs from that approved by the FDA or the manufacturer, you and your health care provider will be required to submit additional written information to the School Nurse prior to approval.
Once the request has been approved by the School Nurse, you will be required to bring the medication to school properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T-Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

For special equipment, services in school will be provided only if you have such equipment in your home. You must provide the equipment as well as repair and replace it when necessary. After the request is approved, you will be asked to bring the equipment to school and to demonstrate its use to selected school staff. Operating instructions must accompany the equipment.
This procedure must be repeated each school year and/or each time there is a change in dosage.
Parents/guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days, or by the last day of school, will be destroyed/discarded.
If you have any questions on this procedure, please contact the school nurse or school principal.

Thank you .