THE SCHOOL DISTRICT OF
PHILADELPHIA

Student Emergency /Medical Information

Last Name:_____First Name:_____DOB: _____

School:_____Room/Sec:_____Grade:_____

Home Address: _____ Home phone: _____

Parent: _____email: _____phone: _____

Parent:_____email: _____phone: _____

Guardian: _____email: _____phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child **Phone**

1._____

2._____

Childs Doctor/Clinic: _____Phone:_____

Medical Insurance: MA___ CHIP____ Private_____

Insurance company name: _____ Policy Number_____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	**YES**	**NO**
Ibuprofen (Advil, Motrin)	**YES**	**NO**

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _____

_____

Other Health Problems: _____

_____

_____

Does your child take medication? ____NO ____YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities. 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**_____

Revised S-865 (06/2018)

THE SCHOOL DISTRICT OF PHILADELPHIA
School Health Services

To the Parent/Guardian of: _____ DOB: _____ Grade: _____
School: _____ Date of Notification: _____

The School District of Philadelphia and Pennsylvania Department of Health require all students attending school to be immunized.
The above student is conditionally enrolled in the School District of Philadelphia according to PA Department of Health requirements.
The parent / guardian of the student has 5 business days from the first day of school or enrollment to provide the information listed below to avoid exclusion from school.
____ Proof of the immunization record provided to the School Nurse by _____, 20___.

OR

____ Proof of an appointment provided to the School Nurse in the form of an appointment card or letter signed by the Health Care Provider. This must be provided to the School Nurse by _____, 20___.
Failure to be fully immunized or one missed appointment will result in exclusion from school until the vaccine is given and verification provided.
Call your child's doctor to schedule an appointment. If you do not have a doctor or cannot get an appointment, you may set up an appointment by calling:

City District Health Centers – 215-685-2933

Please see below for the specific vaccines your child is missing and take this sheet with you to your child's physician appointment

Regulations are as follows for all students in grades K-12: ***Your child needs:***

- **4 doses of Tetanus, Diptheria and Acellular Pertussis (DPT)** _____**Doses of Dtap**
  (1 dose on or after the 4th birthday unless 3rd dose after age 4 or is 6 months after 2nd dose)
- **4 doses of Polio** _____**doses of Polio**
  (4th dose on or after 4th birthday & 6 months after 3rd dose)
- **2 doses of Measles, Mumps, Rubella** _____**doses of MMR**
- **3 doses of Hepatitis B** _____**doses of Hep B**
- **2 doses of Varicella (chickenpox vaccine)** _____**doses of varicella**
  (or documentation of immunity/having disease from a parent, physician, CRNP, PA or laboratory)

Students entering 7th grade and in grades 8-12th need the following additional vaccines:

- **1 dose of Tetanus, Diptheria and Acellular Pertussis (TDAP)** _____**dose of Tdap**
- **1 dose of Meningococcal Conjugate Vaccine (MCV)** _____**dose of MCV**

Students entering grade 12 or at the age of 18 years, need the following vaccines:

- **A second dose of Meningococcal Conjugate Vaccine (MCV)** _____**dose of MCV**
  ***If first dose was given at age of 16 years or older this dose is not needed.**

We cannot overstate the importance of making sure our students are attending school every day, on time, and are healthy and ready to learn. If you have any questions please visit http://kids.phila.gov/index.php/new-school-immunizations-requirements-frequently-asked-questions. Or call your school nurse.

_____ _____
School Nurse Phone Number

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

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

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. E. Medical Exemption/Program Modification Form MEH-23)

   Specify Restrictions:_____
7. List all medications currently being taken:

   Medications:_____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

REPORT OF PRIVATE DENTAL EXAMINATION

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

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments / Follow-up Treatment / Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

_____
Certified School Nurse/Practitioner

_____
School

_____
School Address

_____
Phone Number

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 _____