Dear Parents/Guardians:

The Pennsylvania School Health Law requires all students to have Medical and Dental exams within one year prior to a student’s entry into the grade in which an exam is required:

- Medical Exam (for all new students & Kindergarten, 6th grade & 11th grade)
- Dental Exam (for all new students & Kindergarten, 3rd grade & 7th grade)

If the student’s examination history does not meet these timelines, please make the necessary arrangements to have examinations. If a student is entering Cheltenham School District and/or the 6th or 11th grade, I recommend that the aforementioned examinations be conducted by a family physician and/or dentist who is familiar with the student’s health history and would be in the best position to recommend immediate steps for necessary remedial care. If you do not have a private physician at this time, please see enclosed material.

Under regulations of the Pennsylvania Department of Health, the following immunizations are required for all students, K-12, as a condition for attendance to school. **Those children whose immunization record is incomplete or not provided will be excluded from school.**

Children **IN ALL GRADES** need the following:

- 4 doses of tetanus*  (1 dose on or after the 4th birthday)
- 4 doses of diphtheria* (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles**
- 2 doses of mumps**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 doses of varicella (chicken pox) vaccine or history of disease
- A tuberculosis (TB) test with **negative reading** is required of any new enrollee from foreign countries, homeless, TB endemic area and any situation deemed high risk.
  *usually given as DTP or DTaP or DT or Td  ** usually given as MMR

Children **entering 7th grade** need the following:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) (if 5 years has elapsed since last tetanus)
- 1 dose of meningococcal conjugate vaccine (MCV)

If you child is exempt for medical reasons or religious beliefs, please provide written documentation stating the reason. If your child is exempt from immunizations, he/she may be removed from school during an outbreak.

Please return completed forms to your child’s school nurse.

Sincerely,
Alex Knabb, RN, BSN
Nursing Coordinator, Certified School Nurse
Student's name ________________________________

Date of birth __________________________ Age at time of exam ________ Gender: ☐ Male ☐ Female

Today's date __________________________

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...

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...

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...

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
☐ 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...

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...

27. Had any rashes, pressure sores, or other skin problems?

28. Ever had herpes or a MRSA skin infection?

GENITOURINARY: Has the student...

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:

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...

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
☐ Inherited disease/syndrome
☐ Asthma/lung problems
☐ Kidney problems
☐ Behavioral health issue
☐ Seizure disorder
☐ Diabetes
☐ 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
☐ QT syndrome
☐ Cardiomyopathy
☐ Marfan syndrome
☐ High blood pressure
☐ Ventricular tachycardia
☐ High cholesterol
☐ 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 __________________________

**PHYSICAL EXAM**

**STUDENT’S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION:** Yes ☐ No ☐

<table>
<thead>
<tr>
<th>Physical exam for grade:</th>
<th>CHECK ONE</th>
<th>*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>K/1 ☐ 6 ☐ 11 ☐ Other</td>
<td>Normal</td>
<td>*ABNORMAL DEFER</td>
</tr>
</tbody>
</table>

- **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**

<table>
<thead>
<tr>
<th>TUBERCULIN TEST</th>
<th>DATE APPLIED</th>
<th>DATE READ</th>
<th>RESULT/FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
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**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 ☐
**IMMUNIZATION HISTORY**

**HEALTH CARE PROVIDERS:** Please photocopy immunization history from student’s record – OR – insert information below.

---

**IMMUNIZATION EXEMPTION(S):**

<table>
<thead>
<tr>
<th>Medical</th>
<th>Date Issued:</th>
<th>Reason:</th>
<th>Date Rescinded:</th>
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</thead>
<tbody>
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</tbody>
</table>

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

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**VACCINE**

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT</td>
<td>1</td>
</tr>
<tr>
<td>Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td</td>
<td>1</td>
</tr>
<tr>
<td>Polio Type: OPV or IPV</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td>1</td>
</tr>
<tr>
<td>Mumps disease diagnosed by physician</td>
<td>1</td>
</tr>
<tr>
<td>Varicella: Vaccine</td>
<td>1</td>
</tr>
<tr>
<td>Varicella: Disease</td>
<td>1</td>
</tr>
<tr>
<td>Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella</td>
<td>1</td>
</tr>
<tr>
<td>Meningococcal Conjugate Vaccine (MCV4)</td>
<td>1</td>
</tr>
<tr>
<td>Human Papilloma Virus (HPV) Type: HPV2 or HPV4</td>
<td>1</td>
</tr>
<tr>
<td>Influenza Type: TIV (injected) LAIV (nasal)</td>
<td>1</td>
</tr>
<tr>
<td>Haemophilus Influenzae Type b (Hib)</td>
<td>1</td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>1</td>
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<tr>
<td>Rotavirus</td>
<td>1</td>
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**Other Vaccines: (Type and Date)**

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