COUNCIL ROCK SCHOOL DISTRICT

Dear Physician,
In order to comply with Pennsylvania Immunization Law, we request that you complete this form and return it to the parent or guardian of the child named below so that they may register in our school district.

Student _____ **Date of Birth** _____ **Entering Grade** _____

IMMUNIZATIONS AND TESTS (shading represents required Immunizations)

VACCINE	*Enter Month, Day, and Year each immunization was given* DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
MMR 1st dose after 1 yr of age	1 / /	2 / /			
Measles 1st dose after 1 yr of age	1 / /	2 / /			
Mumps 1st dose after 1 yr of age	1 / /	2 / /	2nd dose of Mumps		
Rubella after 1 yr of age	1 / /				
Hepatitis B	1 / /	2 / /	3 / /		
Hepatitis A (not required)	1 / /	2 / /	3 / /		
HIB (not required)	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	2nd dose of Varicella	Varicella Disease or Lab Evidence Date: _____	
Children Attending 7th Gr: Meningococcal Conjugate (MCV) _____/_____/_____			Tetanus, Diphtheria and Acellular Pertussis Tdap _____/_____/_____		
Other _____/_____/_____					

These requirements allow for medical reasons and religious beliefs. If your child is exempt from immunizations, he/she may be removed from school during an outbreak.

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health.

☐ RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or guardian.

FOR ATTENDANCE IN ALL GRADES:
Children 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** (MMR)
- **2 doses of mumps ** (MMR)**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- **2** doses of Varicella (chickenpox) vaccine or history of disease

*Usually given as DTP or DtaP or DT or Td
**Usually given as MMR

CHILDREN ATTENDING 7TH GRADE NEED THE FOLLOWING:
- **1** dose of tetanus, diphtheria, accellular pertussis **(Tdap)** (if 5 years has elapsed since last tetanus immunization)
- 1 dose of meningococcal conjugate vaccine **(MCV)**

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

Date _____ Physician Signature _____

Physician Address _____

37(11/11) Physician Telephone _____

Council Rock School District
Bucks County Pennsylvania

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20_____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____ DATE OF BIRTH _____ SEX M F

Last First Middle

ADDRESS _____

No. and Street City or Post Office Borough or Township County State Zip Code

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

VACCINE	Enter month, day & year each immunization was given DOSES			BOOSTERS & DATES		
Diphtheria and Tetanus (circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /	Tdap 7th gr / /
Polio (circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /	
MMR 1st dose after 1 yr of age	1 / /	2 / /				
Measles 1st dose after 1 yr of age	1 / /	2 / /				
Mumps 1st dose after 1 yr of age	1 / /	2 / /				
Rubella after 1 yr of age	1 / /					
Hepatitis B	1 / /	2 / /	3 / /			
Hepatitis A (not required)	1 / /	2 / /	3 / /			
HIB (not required)	1 / /	2 / /	3 / /			
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____			
Entering 7th grade: **Meningococcal Conjugate (MCV)**		1 / /				
Other	1 / /	2 / /	3 / /			

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health.

☐ RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or guardian.

If Applicable:

Tuberculin Tests	Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**			**Signature**		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____ (Date)
Result of Diagnostic Studies: _____ (Date)
Preventive Anti-Tuberculosis – Chemotherapy ordered: NO YES _____ (Date)

00 (H511.336) (11/11)

Significant Medical Conditions (√)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (√)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
Print Name of Examiner

_____
Address

_____
Telephone Number

COUNCIL ROCK SCHOOL DISTRICT

FAMILY HEALTH HISTORY

Child's Name _____ M☐ F☐ Birth Date _____

Address _____

Telephone _____ Birth Place _____

Father's Name _____ Mother's Name _____

Family Doctor _____ Telephone _____

Name of Pre-School Program _____

_____

CHILD'S HISTORY

Does your child have:	Yes	No
Allergies	___	___
If yes, explain _____		
Asthma	___	___
Ear Infections	___	___
Convulsions	___	___
Frequent Colds	___	___
Frequent Sore Throats	___	___
Speech Difficulties	___	___
Vision Problems	___	___
Other Concerns	___	___
Is your child on any medications	___	___
List medications _____		
_____		

Has your child had:	Yes	Date (yr)
Chickenpox	___	_____
Head Injury/Concussion	___	_____
Febrile Convulsions	___	_____
Hepatitis	___	_____
Measles, German	___	_____
Measles, Regular	___	_____
Mononucleosis	___	_____
Mumps	___	_____
Polio	___	_____
Rheumatic Fever	___	_____
Scarlet Fever	___	_____
Whopping Cough	___	_____
Other _____		

If your child has a history of **Head Injury/Concussion** – Please explain: _____

_____

Did mother have measles or other serious illness during pregnancy? _____

Was oxygen administered to your child at birth? _____

Any serious illnesses or surgery? _____ If yes, what? _____

Is your child under medical treatment? _____ If yes, explain _____

State any other information which would aid the school in a better understanding of your child.

_____

Family History

Is there a history of:	Yes	Relationship
Allergies	___	_____
Asthma	___	_____
Color Deficiency (Blindness)	___	_____
Convulsive Disorders	___	_____
Diabetes	___	_____
Hearing Disorders	___	_____
Reading Disorders	___	_____
Tuberculosis	___	_____
Visual Disorder	___	_____
Other	___	_____

Child's Developmental History

Birth Weight _____

Age Walked _____

Age Talked _____

Age Toilet Trained _____

Age Stopped Bed-Wetting _____

_____ _____

Date *Signature of Parent/Guardian*

COUNCIL ROCK SCHOOL DISTRICT

STUDENT HEALTH & EMERGENCY CONTACT INFORMATION

COMPLETE THIS SECTION FOR ELEMENTARY SCHOOL STUDENTS

Student Name: _____ School: _____ Grade: _____

Student Health & Emergency Contact Information:

Local persons to be called in case of emergency (accident, illness or dismissal) if a parent cannot be reached, in order of preference:

Last Name: First Name: Relationship: Home Phone: Work Phone: Cell Phone:

Physician's Name:_____ Office Phone:_____ Office Fax:_____

Significant Health Problems:_____

Permanent childcare arrangements (circle one): AM PM

Name of Care Giver:_____ Phone:_____ Cell Phone:_____

The school nurses have standing orders from the school district medical advisor to administer acetaminophen (generic Tylenol) when necessary with parental consent. Please initial** below if you permit your child to receive this medication.

My child may receive acetaminophen according to the standing orders. **Initial here_____

In the event that all named persons on this form (guardians, physicians, emergency and other contacts) cannot be reached, I authorize the officials of Council Rock School District to take whatever action is deemed necessary, in the event of a health emergency for my child.

_____ _____ _____

Parent / Guardian Name (Please Print) *Date* *Parent / Guardian Signature*

COMPLETE THIS SECTION FOR SECONDARY SCHOOL STUDENTS

Student Name: _____ School: _____ Grade: _____

Student Health & Emergency Contact Information:

Local persons to be called in case of emergency (accident, illness or dismissal) if a parent cannot be reached, in order of preference:

Last Name: First Name: Relationship: Home Phone: Work Phone: Cell Phone:

Physician's Name:_____ Office Phone:_____ Office Fax:_____

Significant Health Problems:_____

The school nurses have standing orders from the school district medical advisor to administer acetaminophen (generic Tylenol) when necessary with parental consent. Please initial** below if you permit your child to receive this medication.

My child may receive acetaminophen according to the standing orders. **Initial here_____

My child may receive ibuprofen according to the standing orders. **Initial here_____

In the event that all named persons on this form (guardians, physicians, emergency and other contacts) cannot be reached, I authorize the officials of Council Rock School District to take whatever action is deemed necessary, in the event of a health emergency for my child.

_____ _____ _____

Parent / Guardian Name (Please Print) *Date* *Parent / Guardian Signature*

COUNCIL ROCK SCHOOL DISTRICT
Bucks County, Pennsylvania

Dear Parent or Guardian,

Prescribed medications which are necessary for the health of a child may be administered during the school day. It is recommended that, whenever possible, all medications be administered at home by the parent or guardian. The first dose of any new medication should always be administered at home to ensure close observation of any adverse reaction. If your physician decides it is necessary for your child to receive a medication during school hours, the parent or guardian may request that the school nurse administer the physician prescribed medication at scheduled times. The following school district policies apply to all medications brought to school:

- The "Permission to Administer Medications in School" form below must be completed and signed by the physician and the parent or guardian for all medications - both prescribed and over-the-counter.
- Medication must be sent to school in the original pharmacy container with the current prescription label. Upon request, pharmacies can prepare a duplicate container to be used for school.
- All medications must be brought directly to the health office by the parent, guardian, or a responsible adult designated in writing by the parent or guardian.
- Students who have medications of any kind in their possession (in lunch boxes, school bags, etc.) may be considered in violation of the school district drug and alcohol policies and may be subject to disciplinary action.
- A licensed registered nurse employed by the school district shall be the only district employee responsible for the administration of medications.
- If a licensed registered nurse is unavailable to administer the medication on a time schedule determined by the student's physician, the school nurse and parent or guardian will develop a care plan to ensure that the dosage is administered as scheduled.
- All medications are kept in the health office in a locked cabinet.
- Acetaminophen, for which the district has a standing order from the district physician, will be administered as needed to all students with the signed permission of parent or guardian as noted on the student's emergency information form.
- Ibuprofen, for which the district has a standing order from the district physician, will be administered as needed to students in grades 7-12 with the signed permission of parent or guardian as noted on the student's emergency information form.

Please take this form to your physician and have the instructions recorded below regarding the administration of your child's medication.

Permission to Administer Medications in School

Date medication to start _____ Date to discontinue _____

Name of student _____ Grade/teacher _____

Diagnosis _____

Name of medication _____ Strength _____ Dosage _____

Frequency of administration _____ Recommended time of administration _____

Special instructions/effects to observe _____

Other medications this child is presently taking _____

Signature of physician _____

Telephone number of physician _____

I hereby give permission for the school nurse to administer this medication to my child during the school day.

Date _____ Signature of parent or guardian _____