Mercer Area School District
School Health Requirements

Dear Parent/Guardian:

Pennsylvania School Health Law requires a physical examination for all children in kindergarten, sixth, and eleventh grade. It also requires a dental examination for students in kindergarten, third, and seventh grade. These grades were selected because they represent critical periods of growth and development in a child's life.

You will receive a copy of the medical forms which need completed at kindergarten registration, in your child's report card at the end of second grade (dental form), the end of fifth grade (physical form), the end of sixth grade (dental form) and the end of tenth grade (physical form).

It is highly recommended that your child be examined by your private physician and dentist. They will be able to update immunizations and evaluate the health of your child. However, we do understand that is not always possible. For those students who are not examined by a private physician, a school physician or school dentist will perform the examination at the school with your consent. A separate permission form will be sent home at that time.

The School Health and Immunization Law states that children in **ALL** grades (K-12) need the following **immunizations for attendance**:

- **4 doses of DTP (Diphtheria/Tetanus/Acellular Pertussis)** one dose being after the 4th birthday
- **4 doses of Polio** (4th dose after the 4th birthday and at least 6 months after previous dose given)
- **2 doses of MMR (Measles/Mumps/Rubella)**
- **3 doses of Hepatitis B**
- **2 doses of Varicella (chicken pox) or proof of chicken pox disease**

Proof of vaccines must be in writing from the physician or Department of Health. Your child's record of immunizations must then be submitted to the school nurse for approval.

*Exemptions to immunizations must be filed with the health office before the first day of school.

This form and your signature acknowledge that you have been informed of the required examinations and immunizations during your child's school years and the health services that they will receive while attending Mercer Area School District. Please see the Mandated School Health Services form for an overall view of these services.

Student's Name: _____

Parent/Guardian Signature: _____

Date: _____

Date of Issue January 2016

Provision of School Health Services and Mandated School Health Services

School entities are to provide the following health services for students who attend or who should attend an elementary, grade or high school, either public or private, and children who are attending a kindergarten which is an integral part of a local school district. These requirements also apply to students who are home schooled.

Mandated School Health Services

SERVICE	K	1	2	3	4	5	6	7	8	9	10	11	12	Ungraded	Notes
School Nurse Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Maintenance of Health Record	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Immunization Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Medical Examination	*	*					X					X		Age Appropriate	*Required on original entry- K or 1st grade
Dental Examination	*	*		X				X						Age Appropriate	*Required on original entry- K or 1st grade
Growth Screen	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Hearing Screen	X	X	X	X				X				X		X	
Scoliosis Screen							X	X							6th grade physical may be used in lieu of 6th grade screen
Tuberculin Test	*	*								X				Age Appropriate	*Required on original entry- K or 1st grade. Unless approved to discontinue
Vision Screen-Far Visual Acuity Test	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Vision Screen-Near Visual Acuity Test	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Vision Screen-Convex Lens Test (Plus Lens)		X												As Needed	1st grade students meeting criteria & new students (any gr) not previously screened
Vision Screen-Color Vision Test		*	*											As Needed	*1st or 2nd grade & new students (any gr) not previously screened
Vision Screen-Stereo/Depth Perception Test		*	*											As Needed	*1st or 2nd grade & new students (any gr) not previously screened

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 ☐ 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_____

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 ☐**

STUDENT NAME:

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

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

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

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME:

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

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

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								**LEFT**								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address