2018-2019
HEALTH FORMS

Return date: August 1, 2018

STEPS FOR ONLINE COMPLETION:

1. **COMPLETE all required "fillable" areas online. Then…**
2. **PRINT entire health form.**
3. **SIGN pages where indicated by ★. In some cases, both parent and student signature is required.**
4. **ATTACH a copy of health insurance card and prescription insurance card where indicated. (In many cases, these are the same card.)**
5. **Bring TURQUIOSE highlighted Health Form pages to healthcare provider for completion. These include:**
   - Physical Exam and Tuberculosis screening: The Hill School mandates all students submit a new health form annually, including documentation of a physical exam performed by his/her healthcare provider and completed **AFTER** May 1, 2018 (4 months prior to the start of classes).
     - The Health Center will NOT ACCEPT a physical exam performed by a healthcare provider who is also the student's parent.
     - Many healthcare providers prefer to use their own physical form. These are acceptable. Please ensure the SPORTS ACTIVITY CLEARANCE is specified.
   - Medication Order Form
   - Complete Immunization History required of ALL new students. Retuning students need only provide documentation of UPDATED vaccines
     The following vaccines are required for school attendance by the State of Pennsylvania

Diphtheria & Tetanus:	**4 Doses: at least one on/after 4th birthday (DTaP/DTP/DT/Td)**
Tdap:	**1 Dose: (Tdap)**
Polio:	**3 Doses: (OPV/IPV)**
MMR:	**2 Doses: given on/after 1st birthday**
Hepatitis B:	**3 Doses: (HBV)**
Varicella:	**2 Doses: given on/after 1st birthday ***

Meningococcal conjugate vaccine……2 Doses: First dose at age 11-15, 2nd dose required at age 16.
(If the 1st dose is given at age 16 or older, only one dose is required).

*** Or documentation of a history of chickenpox immunity proven by laboratory testing or a written statement of history of chickenpox disease from a parent, guardian or physician.**

6. **RETURN** all forms **BY MAIL** to the Wellness Center by **August 1, 2018.**

To maintain confidentiality, faxing and emailing is NOT allowed

General Information/Health Insurance/Consent to Treat 2018-2019

Check all that apply: ☐ NEW ☐ RETURNING ☐ INTERNATIONAL ☐ DAY ☐ BOARDER

STUDENT NAME_____ **DATE OF BIRTH** _____
LAST, FIRST, MI MM/DD/YYYY

STUDENT Cell #: _____ GENDER: M◯ F◯

MOTHER or Guardian Name: _____ Cell #: _____ Work #: _____

FATHER or Guardian Name: _____ Cell #: _____ Work #: _____

HOME Telephone #: _____

ADDRESS: _____
Number/Street City State Zip Code Country

LIST ALLERGIES AND SIGNIFICANT MEDICAL CONCERNS: _____

EPIPEN: ☐ **YES** ☐ **NO** **EPIPEN required for** _____

Health/Medical Insurance is REQUIRED.

☐ **Check here if you have enrolled your child in the United Healthcare Insurance Plan through our school.**

ATTACH a FRONT & BACK copy of INSURANCE CARD information HERE

REQUIRED

Attach copy of FRONT Of your Health Insurance Card Here

REQUIRED

Attach copy of BACK Of your Health Insurance Card Here

Name of parent policy holder _____ **Date of Birth:** _____

PERMISSION TO TREAT: This permission is required to facilitate timely provision of medical care while your child is attending The Hill School. Every effort will be made to contact the child's parent/guardian for serious illnesses, serious injuries, operations or protracted or complex treatments.
I hereby authorize and grant members of The Hill School's Wellness Center, Athletic Training Department, and other designated adult representatives permission to administer care and treatment for my son/daughter. Such care and treatment shall include: injuries and illness, the administration of medications, and such treatment as deemed necessary in case of an emergency. To ensure compliance with Pennsylvania State Law regarding the school vaccination requirements, I also give permission for the administration of any vaccines (Td, Tdap, IPV, MMR, Hepatitis B, Varicella, and MCV4) if my child does not have documentation of serologic immunity or documentation proving he/she had already received such immunizations. I agree to pay charges for such immunizations. I also give permission to the medical department and school physician (or his/her designee) to hospitalize and or secure proper treatment for my son/daughter in case of a medical/surgical/dental/psychiatric emergency, provided they are unable to communicate with me and, if, according to their best professional judgment, further delay might jeopardize the welfare of my child. I also give permission to release pertinent medical information to The Hill School Faculty on a need-to-know basis as well as to other physicians and therapists to whom the child is referred. I give permission to The Hill School or designated personnel to represent me during the year with full power to authorize and consent to any treatment for my child in an Emergency Room (such as at the local Pottstown Hospital Tower Health), or medical, rehabilitative, mental health or dental office. Furthermore, I understand any and all students may choose to check in with Hill School Counseling professionals on an as-needed basis. In addition, if The Hill School Counseling professionals deem my child to be in need of any ongoing therapeutic counseling support, I will be involved in this decision. **PERMISSION TO PARTICIPATE IN SPORTS/ACTIVITIES:** I hereby acknowledge awareness that participation in all sports, activities and events involves some risk of injury, which may rarely include severe injury, possibly involving paralysis, permanent mental disability or death, and that these injuries may occur in some instances as a result of unavoidable accident. I hereby accept these risks and give consent to participation by my child in all sports, activities and events while he/she is attending school.

Parent/Guardian Signature: _____ **Date:** _____

The health form is not part of the student's permanent transcript. The information will be used as an aid to providing necessary health care while your son/daughter is a student here at The Hill School. Your knowledge and consent will be required for release of this record. This page of the Health Form constitutes a permission statement, which must be signed by parent/guardian. **This cover page will be photocopied and used as a permission form.**

IMPORTANT: **FORMS WITH INCOMPLETE OR UNANSWERED QUESTIONS WILL BE RETURNED FOR COMPLETION.**

PHARMACY INFORMATION - *REQUIRED* *FOR ALL STUDENTS*

Even though your child may not be prescribed any medication now, there may be a need for him/her to do so during the school year. The Hill School Wellness Center maintains a long standing relationship with a local pharmacy in Pottstown. Most all of our students' prescriptions and requests for over-the-counter medications are filled here and delivered same day to our office. The Prescription Insurance Card information will be shared with this Pharmacy. Costs not covered by the insurance will be billed to the student's Hill School account.

Professional Pharmacy
920 N. Charlotte St.
Pottstown, PA 19464
610-323-2115

STUDENT NAME_____**DATE OF BIRTH** _____

Medication allergies: **YES**☐ **NO**☐ List: _____

REQUIRED:

PROVIDE FRONT & BACK COPY OF
PRESCRIPTION INSURANCE **CARD even if SAME AS HEALTH INSURANCE CARD**

Attach copy of the
FRONT
Of
PRESCRIPTION INSURANCE CARD
(This may be the same as Health Insurance card)

HERE

Attach copy of the
BACK
Of
PRESCRIPTION INSURANCE CARD
(This may be the same as Health Insurance card)

HERE

LAB INFORMATION – *REQUIRED*

The Hill School Wellness Center uses the services of three local laboratories in our local area in the event lab work is necessary.

Please choose the one which is accepted by YOUR CHILD's Insurance:

_____☐**LabCorps** _____☐**Quest** _____ **Pottstown Hospital Lab**

Student Name: _____

IMPORTANT NOTICE OF PRIVACY: This information is strictly for the use of the Wellness Center in providing necessary health care while you are a student at The Hill School. Confidentiality of all health information will be strictly observed. It will not be released to anyone without your knowledge and consent. This form is to be filled out by a parent and reviewed by the child's physician.

HEALTH HISTORY- *Mark "X" in the YES column if your child has had or has any of the following:*

Do you have now or ever had the following:	Yes	Dates/Comments
Bronchitis/Pneumonia		
Chicken Pox		
Ear Infections		
Headaches		
Hepatitis		
Lyme Disease		
Malaria		
Measles		
Meningitis		
Mononucleosis		
Mumps		
Pertussis		
Shingles		
Sinusitis		
Skin problems		
Tuberculosis (TB)		
SURGERY		
Appendectomy		
Hernia Repair		
Tonsillectomy		
Orthopedic:		
OTHER:		
FEMALES ONLY:		
Age of onset of menses		
Irregular periods		
History of severe cramps		
GYN conditions		
Taking Birth Control Pill		
OTHER:		

FAMILY	OCCUPATION	AGE	HEALTH STATUS
Father			
Mother			
Sister			
Sister			
Sister			
Brother			
Brother			
Brother			

VISION/ HEARING/ SPEECH	Describe:		
Wears Glasses	**Yes**	**No**	
	◯	◯	

ALLERGIES	Yes	Comments
FOOD		Name food:
INSECTS		
OTHER		Name allergy:
EPIPEN Rx		
CHRONIC ILLNESSES		
Cardiac		Medication?
Fainting/dizziness		
Mitral Valve Prolapse		
Heart murmur		
OTHER		
Endocrine		
Diabetes		Medication?
Insulin injection		
Insulin pump		
Thyroid		
OTHER		
Gastrointestinal		Medication?
Chronic constipation		
Ulcers		
Weight Changes		
OTHER		
Genito-Urinary		Medication?
Musculoskeletal		Medication?
Congenital Deformities		
Orthopedic problems		
Surgical history		
OTHER		
Neurological		
Concussion		
Seizures		Medication?
Learning Disabilities ADD/ADHD		Medication?
OTHER		
Psychiatric		
Anxiety/Panic		Medication?
Depression		
Disordered Eating		
Sleep Walking		
Substance Abuse		Treatment?
OTHER		
Respiratory		
Asthma		Medication?
OTHER		

REPORT OF PHYSICAL EXAM 2018-2019 Healthcare Provider to complete

The Health Center will NOT ACCEPT a physical exam performed by a Health Care Provider who is also the student's parent.

STUDENT NAME_____**DATE OF BIRTH** _____

LIST ALL ALLERGIES: _____ **REQUIRES EPIPEN: YES**___ **NO**___

Physical Measurements

Height _____ Weight _____ BMI _____%

BP _____ Pulse _____

Urine Dip: (if indicated) _____

Screening Data

Scoliosis: YES ____ NO____ Treatment _____

Vision: Right 20/ ___ Left 20/ ___Corrected _____

Hearing: Right ___ Left ____ Corrected _____

Sickle cell trait/disease: (only if indicated) YES____ NO_____

Physical Examination

Document any abnormalities of the systems and Describe them fully. Use additional sheets if necessary.

	WNL	Abnormal *list details*
Congenital		
HEENT		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

Tuberculosis (TB) Risk Assessment and Testing*

___Yes ___ No Does the student have a history of or close contact with a person who has active TB?

___Yes ___ No Was this student born in a country with a high prevalence of TB (Africa, Middle East, Asia (except Japan) Central/South America, Caribbean, Mexico and Eastern Europe)?

___Yes ___ No Has this student lived or had extensive travel (>4 weeks) within past 5 years in a high prevalence country?

If the answer to all questions is "NO", then no NEW TB test is required. If the answer to any question above is "YES", the student is REQUIRED to have an IGRA BLOOD TEST no more than 4 months prior to attending school. These tests are commercially called Quantiferon Gold and T-Spot. If the TB test is positive, provide a chest x-ray report and details of any drug treatment below.

Furthermore, indicate if the student was previously diagnosed with ACTIVE or LATENT tuberculosis infection: _____

(Circle Test performed)	**DATE**	**RESULT**
Blood Test: QFT-GIT or T-Spot	_____	_____
Chest XRAY	_____	_____
Treatment Details:	_____	

- **Significant Past Medical History**: _____
- **Hx Concussion:** No / Yes Date(s):_____ **Hx Fainting w/exercise:** No / Yes: Date:_____ (**Only if indicated: EKG Results**: _____)
- **Is there loss or seriously impaired function of paired organ**? No / Yes (list): _____
- Is or has the patient been under treatment for any medical or emotional condition? No / Yes **(complete medication forms)**

If YES, please explain: _____

REQUIRED: I have examined the above named student and declare the following regarding **SPORTS ACTIVITY CLEARANCE:**

SELECT ONE: ☐ CLEARED-NO Limitations ☐ CLEARED **W/**Limitations (list) _____ ☐ **NOT CLEARED**

If NOT cleared, EXPLAIN: _____

Health Care Provider *signature*: _____ **Date of Exam:** _____

(Must be after 5/1/2018)

Health Care Provider *print*: _____

Address _____ Phone _____ Fax _____

COMPLETE IMMUNIZATION HISTORY 2018-2019 Healthcare Provider to complete

STUDENT NAME_____**DATE OF BIRTH** _____

ALL NEW STUDENTS – See Pennsylvania State immunization requirements listed here and have Health Care Provider complete the grid below. Provider's office form is also acceptable.

RETURNING STUDENTS: list ONLY newly received vaccines in grid below.

The following vaccines are REQUIRED for school attendance by the State of Pennsylvania:

- 4 doses: Tetanus, diphtheria & acellular pertussis* (1 dose on/after the 4th birthday) *Usually given as DTaP or DTP or DT or Td
- 1 dose: Tdap
- 4 doses: Polio (4th dose on/after the 4th birthday)
- 2 doses: MMR
- 3 doses: Hepatitis B
- 2 doses: Varicella (chicken pox) or evidence of immunity **
- 2 doses: Meningococcal conjugate vaccine-
  - first dose given 11-15 years old, a second dose required at age 16
  - If the first dose is given at 16 years or older, only one dose is required.

** Documentation of a history of chickenpox immunity proven by laboratory testing or a written statement of history of chickenpox disease from a parent, guardian or physician.

REFERENCES: Requirements from The Pennsylvania Code – Subchapter C. *IMMUNIZATION* §23.81, amended 2017

Record dates with **EXACT** Month, Day, Year (xx/xx/xxxx)

	1	2	3	4	5
DTaP, DPT, DT, Td					
Tdap ***(1 dose)***					
Polio (OPV/IPV*)* ***(1 dose after age 4 year)***					
Hepatitis B ***(3 doses)*** ***(or 2 dose series of Recombivax age 11-14)***					
MMR ***(2 doses on/after age 1 year)***					
Varicella Vaccine ***(2 doses on/after age 1 year)***					
History of Chicken Pox *Disease*	**Date:**				
Menactra (MCV4)					
Menomune®- A/C/Y/W-135					
Meningococcal B vaccine (recommended) **Bexsero / Trumenba**					
Gardasil (recommended)					

Health Care Provider *signature*: _____

Health Care Provider *print*: _____

Address _____ Phone _____ Fax _____

OVER-THE-COUNTER (OTC) & PRESCRIPTION MEDICATION POLICY & AGREEMENT

STUDENT NAME_____

POLICY: Pennsylvania State law requires appropriate management of medication in the school setting. The Hill School medication policy has been developed to ensure the health and safety of all of our students. The Wellness Center must be notified of all student medications, including prescribed, over-the-counter (OTC), and other medications, such as herbs, homeopathic and otherwise. The Medication Policy is clearly defined in The Hill School Handbook for your review.

RE: OTC MEDICATIONS- (Non-Prescription Medications):

- Boarders are allowed to have a small amount of FDA approved OTC medication in their room for the treatment of minor discomforts such as headache, menstrual cramps, cough, and stomach ache.
- ALL medication must be purchased in the UNITED STATES, and must be labeled in ENGLISH.
- Students cannot share their medication with anyone else.
- All OTC medication must be in the original manufacturer's labeled container.

RE: NUTRITIONIAL SUPPLEMENTS AND PERFORMANCE-ENHANCING PRODUCTS

- The Hill School Wellness Center regards and respects the policy statement from the AAP which emphasizes "The American Academy of Pediatrics strongly condemns the use of performance-enhancing substances and vigorously endorses efforts to eliminate their use among children and adolescents". Therefore, students are not allowed to use nutritional supplements or performance enhancing products without an explicit medical order from their physician.
- NOTE: Students are NOT ALLOWED to make online purchases / accept mail delivery of: medication, nutritional / herbal supplements, performance enhancing formulas, weight loss/gain products.

RE: PRESCRIPTION MEDICATIONS:

- All prescriptions must be purchased from a **United States Pharmacy** and remain in the original labeled container from that Pharmacy.
- International students taking prescription medication may require assistance with this condition and should contact the Wellness Center for prescription support.
- All medication must be brought to the Wellness Center; at the beginning of the school year, as well as any new medications prescribed during the course of the school year.
- ***A Medication Order Form*** must be completed by a licensed prescriber for each medication and with subsequent order changes. One can be obtained through the Wellness Center
- Parents must update the Wellness Center with any insurance changes during the school year as needed.
- Parents should inform the Wellness Center if prescription refills need to be obtained from a source other than Pottstown's Professional Pharmacy.

Student and Parent please read and sign the OTC & Prescription Medication Agreement below.

OTC & Prescription Medication Agreement

I, Hill Student, hereby agree to comply with The Hill School's policy regarding medication:

1. I will bring my medication to The Wellness Center along with a written medical order from my prescribing physician upon immediate arrival to campus and throughout the year as necessary.
2. I understand all schedule II and psychotropic medications (for example, but not limited to, medication for ADD/ADHD, seizure disorder, depression, anxiety, and others) are required to be kept in the Wellness Center.
3. I understand some prescription medication may be kept in my room and self-administered with Wellness Center permission, such as medication for asthma, anaphylaxis, diabetes, oral contraceptives and others. All such medication must be examined by the Wellness Center.
4. I will pick up my medication according to the administration schedule determined by the Wellness Center medical staff.
5. I will take my medication according to prescription directions and return any unused medication to the Wellness Center.
6. I will not engage in misuse or abuse of my medication whether it involves other individuals or me.
7. I understand that misuse of or abuse of medication can result in disciplinary action by the School.
8. I understand that failure to report to the Wellness Center for my medication can result in demerits and/or disciplinary action.
9. I understand the Wellness Center does not support the use of nutritional supplements and/or performance-enhancing products by our students and I will not purchase or use these products without a Doctor's order.

STUDENT: ***signature***_____ **Date**_____

I, Hill Parent / Guardian, hereby acknowledge that I have read and *reviewed* the OTC PRESCRIPTION MEDICATION POLICY with my child and I agree to comply with the policy as stated. Additionally, I agree to:

1. Hand deliver or **mail directly** to the Wellness Center, the medications that are provided from home.
2. Not give my child medication to bring back to school without prior notification and approval of the Wellness Center medical staff.
3. Notify the Wellness Center of ANY changes in dosing or new prescriptions and provide Provider documentation.
4. I understand that the medication must be in its original container and that the directions match the written Provider's order.

PARENT/GUARDIAN: ***signature***_____ **Date**_____

MEDICATION ORDER FORM 2018-2019 – Healthcare Provider to complete if applicable

☐ **NOT APPLICABLE**

STUDENT NAME_____ **DATE OF BIRTH** _____

DIAGNOSIS _____

Dear Licensed Prescriber,

Your patient is a student at The Hill School and is under your care regarding the management of a prescription medication. School and state regulations require that these medications be administered from the school's Wellness Center and that a written medication order from the licensed prescribing provider be kept on file in the student's medical record.

We work with Pottstown's Professional Pharmacy for prescriptions and refills. Please be sure to discuss a plan for your patient to obtain refill prescriptions from you so that there is little or no interruption of his/her medication. Feel free to contact the Wellness Center directly with any questions.

Sincerely,

Steven M. Evans, D.O.
Medical Director

Sandra Ryder, MS, CPNP-PC
Wellness Center Administrative Director
Pediatric Nurse Practitioner

Kathleen Van Buren, DNP, CPNP-PC
Associate Director
Pediatric Nurse Practitioner

Prescribing Provider *signature*: _____ **Date:** _____

Address _____

Phone _____ Fax _____

Medication Ordering Information

Medication Name	Dose	Frequency	Route	PRN only?	Comments

PARENT REQUEST TO ALLOW SELF-ADMINISTRATION OF MEDICATION 2018-2019

The State of Pennsylvania allows students to possess and self-administer asthma inhalers and epinephrine auto-injectors. Additionally, at the discretion of The Hill School medical staff, boarding students may be allowed to self-administer some other prescription medications with prescriber and parental permission. All such medication must be examined by the Wellness Center. (This does not apply to Schedule II medications such as, but not limited to medications like Ritalin, Concerta, Adderall, Daytrana; and/or other psychotropic medications used to treat disorders such as ADD/ADHD, depression and anxiety).

The Wellness Center reserves the right to revoke the student's privilege of self-administration if there is any question as to the student's competency or compliance in the ability to safely self-administer such medications as stated in the **OVER-THE-COUNTER (OTC) & PRESCRIPTION MEDICATION POLICY & AGREEMENT**

☐ **NOT APPLICABLE**

STUDENT NAME_____ **has been prescribed the following:**
(Must accompany the MEDICATION ORDER FORM completed by licensed prescriber)

	Medication	Dose	Diagnosis
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

I request my child be permitted to self-administer the above medications.

PARENT/GUARDIAN: ***signature***_____ **Date**_____

INFLUENZA VACCINE INFORMATION & CONSENT 2018-2019

Flu:
Each winter, the State of Pennsylvania has an influenza epidemic that can be potentially devastating to the boarding school environment, both to the individuals who become ill and to the school as a whole. Therefore, we offer and **highly recommend** the influenza vaccination to all students and faculty. Influenza (flu) is a respiratory disease caused by influenza virus. The types or strains of influenza virus causing illness may change from year to year, or even within the same year. People who get flu may have fever, chills, headache, dry cough and muscle aches, and may be sick for several days or up to a week or more. Most people recover completely. However, for some people, flu may be especially severe, and pneumonia or other complications including death may result.

Flu vaccine:
The regular flu vaccine contains killed influenza virus of the types selected by the U. S. Public Health Service and the Center for Biologics Evaluation & Research of the U.S. Food and Drug Administration. The types and strains of virus included are those that have most recently caused influenza. The vaccine will **not** make a person ill with the flu because it is a killed virus vaccine. As with any vaccine, flu vaccine may not protect 100% of all susceptible individuals.

Risks & Possible Side Effects:
Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm at the injection site, or possibly fever, chills, headache or muscle aches; these effects usually last 24 to 48 hours. Most people who receive the vaccine either experience no reaction or only mild reactions. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, would occur. Moreover, untoward medical events completely unrelated to vaccine administration may occur co-incidentally in the aftermath period following vaccination.

Contraindications:
- People who have an active neurologic disorder
- People with fever, acute respiratory or other active infections or illnesses
- Some multi-dose formulations may contain a preservative called THIMERASOL

In the fall 2018, the CDC's Vaccine Information Statement (VIS) regarding the 2018-19 Influenza Vaccine will be available on their website for your review. http://www.cdc.gov/vaccines/pubs/vis/default.htm#flu If you have any questions, please check with your physician before granting permission for your child to receive this vaccine.

A nominal charge for this vaccination will be billed to your student's account or to insurance if your child has the School's Student Health Insurance Policy.

I have read the information above, discussed this optional vaccination with my child and **I hereby give permission to The Hill School Wellness Center medical staff to administer the influenza vaccination.**

CHOOSE ONE: **YES** ☐ **NO** ☐

PRINT STUDENT NAME: _____ **DATE OF BIRTH:** _____

PARENT/GUARDIAN: ***signature***_____ **Date**_____

Wellness Center Staff ***to complete the following*:**

Date _____ **Dose**_____ **Site**_____

RN Signature_____

For Wellness Center use:
Affix Vaccine Information Sticker Here

***Note from page 4 regarding* Tuberculosis (TB) Risk Assessment and Testing**

The Pennsylvania Health Department recommends that all students are screened for Tuberculosis. The Hill School Wellness Center requires all students who are deemed high risk for TB be screened for this disease through Interferon-Gamma Release Assay (IGRA) blood testing annually. Students whose screening reveals they are high risk and who come to school without this testing will be sent to our local lab for testing to be completed. For more information on Tuberculosis, please refer to the Center for Disease Prevention for further information at http://www.cdc.gov/tb/publications/factsheets/testing/IGRA.htm

THANK YOU
for completing The Hill School Health Form

- Kindly make certain that you have completed all "fillable" areas.
- **PRINT** the forms and provide **WRITTEN SIGNATURES** where indicated-(marked by a ★).
- **ATTACH** Health Insurance and Prescription Insurance cards where indicated.
- **BRING turquoise coded pages** to Healthcare provider for completion and signature.
- **RETURN** all forms **BY MAIL** to the Wellness Center by **August 1, 2018.**

To maintain confidentiality,

faxing and emailing of forms are not allowed.

A reminder that students will ONLY be allowed to participate in preseason sports and classes once health forms are received and reviewed.

Feel free to contact our office if you have any questions. 610-705-1217

Messages will be checked periodically while the office is closed during the summer break.

We will reopen on August 10, 2018