MT. LEBANON SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT
NEW STUDENT PACKET

Dear Parent/Guardian:
Welcome to our school district. We are pleased you will be joining our school community and hope that your family finds this to be a healthy and supportive learning environment. Please take a moment to read the following information about the nursing services provided at school. If your child has special health care needs, requires medication or health treatments during the school day, or has a chronic health condition, please contact your child's certified school nurse so that we can prepare for his/her entry into school.

EMERGENCY INFORMATION:
Parents/Guardians are required to complete the Emergency Medical Contact/Release Information page on the parent/guardian Dashboard account for their child. This will need to be done when your child's registration is complete and your child has started school in the Mt. Lebanon School District and yearly thereafter. This will ensure that we have the most current contact information.

1. You will need to go into the parent/guardian Dashboard account, not the account belonging to your child.
2. Emergency Medical Contact/Release Information is located under the "account preferences" tab.
3. Please include parents/guardians (in priority order) as part of your 4 (four) contact options if you wish to be contacted - if you do not - you will not be contacted.
4. Please enter this information for each student. You may utilize the "copy" form feature to expedite the process.
5. Students with more than one parent/guardian account or families who do not have computer access will need to contact their child's school secretary to request a hard copy of the Emergency Medical Contact/Release Information sheet. The parent/guardian will then need to complete the form and return it to their child's building. The building staff will then transfer the information electronically.

IMMUNIZATIONS:
All students are required to be in compliance with Pennsylvania and Allegheny County Health Department's Immunization regulations for school attendance. Please see the separate immunization regulations. To comply with these regulations, a copy of your child's immunization record must be submitted, reviewed and approved by the certified school nurse before your child can attend school.

KINDERGARTEN:
All students entering Kindergarten in Allegheny County will be required to have had LEAD testing completed prior to the first day of school. Parents/Guardians will need to submit written proof, signed by their child's health care provider of such testing, to their child's certified school nurse.

HEALTH HISTORY:
Please complete both sides of the health history form and return to your child's nurse's office. This information is kept confidential and shared with appropriate school and medical personnel as deemed necessary.

HEALTH INSURANCE:
If your child does not have health insurance, free or low cost coverage is available through Pennsylvania Children's Health Insurance Program (CHIP). CHIP is administered by the Pennsylvania Insurance Department. For more information, please visit ww.chipcoverpakiksa.com or call 1-800-986-KIDS. Applications are also available in your child's school health office.

(over)

HEALTH CARE TREATMENTS:

Basic health care (first aid) is available in the nurse's office for any illness or injury that occurs during the school day hours. The nurse cannot address injuries that occur at home. Parents are notified for an illness or injury if and as the case warrants. By law, the nurse is not permitted to make a diagnosis or prescribe treatment.

Students who have a temperature equal to or greater than 100 degrees, vomiting, or diarrhea and any other symptom deemed to be potentially contagious will be sent home and should remain at home until symptom free for 24 hours without the use of medication.

Students who have a suspected contagious rash or disease will be sent home with a diagnostic referral. The diagnostic referral must be completed and the student cleared for re-admittance to school by a Pennsylvania Licensed Physician, Physician's Assistant (PA) and/or a Certified Registered Nurse Practitioner (CRNP) prior to the student returning to school. The student must then be signed in through the nurse's office for re-admittance to school. The school district follows the Allegheny County Health Department Guidelines for re-admittance to school following an illness or contagious disease referral.

The district is not equipped to provide advanced emergency care. Students needing urgent or emergency care will be transported to an emergency care facility by a local ambulance service. Please notify the certified school nurse if your child has any health concerns that could result in the need for emergency services, or that need to be communicated to emergency personnel.

The district maintains a policy of Universal or Standard Precautions (procedures that are designed to reduce the risk of transmission of bloodborne pathogens) to insure the health, safety and welfare of our students and staff. Students are taught about possible disease transmission through exposure to blood/body fluids. Students are to report any blood or body fluids spill to a teacher and are never to touch or clean-up another person's blood/body fluid spill.

MANDATED PROCEDURES:

Pennsylvania law mandates the following **screenings**: completed by the Nursing staff

- Vision - Grades K-12 annually
- Hearing - Grades K-3, 7 and 11. Also parent or teacher referrals and students who have known hearing loss
- Height and Weight and BMI % - Grades K-12 annually
- Scoliosis - Grades 6 and 7

Referral forms are mailed home for students who do not pass the school screening and require a more thorough examination by his/her private health care provider.

Pennsylvania law mandates the following **examinations:**

- **Physical -** Grades K, 6, 11 and/or upon first enter into school in Pennsylvania
    - Children transferred from other school systems in Pennsylvania shall be examined as soon as possible after the transfer regardless of their age or grade if an adequate health record is not made available by the original school. Outside of Pennsylvania transfers/new students shall be required to have a new physical.
- **Dental** - Grades K,3, 7 and/or upon first enter into school in Pennsylvania
    - Children transferred from other school systems in Pennsylvania shall be examined as soon as possible (either by their own dentist or the school dentist) after the transfer regardless of their age or grade, if an adequate health record is not made available by the original school. Outside of Pennsylvania transfers/new students shall be required to have a new dental.

Parents are encouraged to have the physical/dental examinations performed by their child's Pennsylvania Licensed Healthcare provider, since he/she is aware of their child's health history and status. These examinations are at the parents expense and are to be submitted to the child's nurses office.
If you prefer, upon parent/guardian request and permission, the school physician or dentist will complete these examinations during the school year at the expense of the district.

MEDICATION (PRESCRIPTION AND NON-PRESCRIPTION)

The administration of medication, both prescription and non-prescription, during school hours, is strongly discouraged for safety reasons and to limit traffic in the nurse's office. However, if a Pennsylvania Licensed Physician, Physicians Assistant and/or Certified Registered Nurse Practitioner deems it medically necessary for a student to take an FDA approved medication, either prescription or non-prescription, during the school day, please abide by the following procedure:

- Medication orders must be dated on or after July 1st of the new school year
- Both prescription and over the counter (non-prescription) medications require an order form a licensed prescriber.
- A new medication order is required for each medication that the student is prescribed (example: Benadryl and an Epinephrine Auto Injector need two (2) different orders).
- Each medication requires the signature of a Pennsylvania Licensed MD/DO, CRNP or PA **AND** the student's parent/guardian. The medication form must be turned in to the nurse's office before any medication can be given by the nurse.
- Prescription medication must come in the labeled pharmacy container with the current dosing instructions on the label.
    - Each time there would be a dosage change of the same medication, along with a new order, a new pharmacy labeled container with new instructions must be submitted.
- Over the counter medication must come in the original, unopened container and must match the dosage/type on the medication form. (example: if *liquid* Tylenol is ordered then *liqui*d Tylenol must be brought in).
- Please be mindful of the medication's expiration date. Expired medications cannot be administered in the school district.
- No Herbal remedies/oils are FDA approved for administration in a school setting

It is the responsibility of the student to report to the nurse's office for his/her medication. Please remember that your child may not receive his/her medication if these procedures are not followed.

Per the state of Pennsylvania, students are only permitted to self carry/self-administer the following medications:

- Epinephrine Auto Injectors
- Rescue Inhalers
- Diabetic medications/supplies

Please be aware it is a violation of the district's drug and alcohol policy to self-carry/self-administer any medication with the only exceptions being: Rescue Inhalers, Epinephrine Auto Injectors and insulin pumps/pens/supplies.

In order for students to self- carry/self-administer the above mentioned emergency medications the following steps are required:

- All paperwork must be completed and submitted to the nurse's office
- Paperwork is reviewed by a certified school nurse and the student completes the self carry/self administer assessment with the certified school nurse in order to self carry their medication.

Refer to the Medication Policy for complete details on medication administration.

If you have questions concerning the above information or other areas pertaining to health services, please contact your child's certified school nurse.

Thank you
The Nursing Services Department

10/21

Mt. Lebanon School District

HEALTH HISTORY (parent completes)

(rev. 5/2020;4/21;1/22)

Student's Name_____Grade_____ Date of Birth_____

Street Address_____

City_____Zip _____ Cell/Home Phone_____

Siblings name	Birth Date	School	Grade

Name and address of school last attended:

Name of school:

Address of school:

Physician:_____ Phone Number:_____

Dentist:_____ Phone Number: _____

Medication: (please list all medications taken):

At Home: _____

At School:_____

(If required at school, complete form ***- Authorization for Medication****)*

OVER

STUDENT NAME:_____ **GRADE:**_____

TO BE COMPLETED BY PARENT

Please check ✔ ALL that applies to your child

Anxiety	☐	*Developmental Delay*	☐	*Nosebleeds*	☐
Arthritis	☐	*Diabetes Type 1*	☐	*Orthopedic Condition*	☐
Asthma	☐	*Diabetes Type 2*	☐	*Rheumatic Disease*	☐
Attention Deficit Disorder	☐	*Dietary Restrictions*	☐	*Sickle Cell*	☐
Autoimmune Disorder	☐	*Epilepsy/Seizure Disorder*	☐	*Speech Difficulty*	☐
Bladder/Bowel Control	☐	*Gastrointestinal Condition*	☐	*Spina Bifida*	☐
Bleeding Disorder	☐	*Hearing Deficit (right/left)*	☐	*TB Exposure*	☐
Blood Pressure Issues - (high or low)	☐	*Immunocompromised*	☐	*Thyroid Condition - specify*	☐
Cancer	☐	*Inflammatory Bowel Disease*	☐	*Tourette's Syndrome*	☐
Cardiovascular Condition - specify	☐	*Kidney Condition*	☐	*Vision: Eye Surgery - specify*	☐
Cerebral Palsy	☐	*Mental Health Diagnosis*	☐	*Severe Vision Loss - right/left*	☐
Chicken Pox(date)	☐	*Migraines*	☐		
Color Vision Deficiency	☐	*Neurological Disorder*	☐		
Dental Condition	☐				

*Explain Above Check Marks:*_____

*Allergies/Reaction:*_____

*Previous Surgeries/Dates:*_____

Other: _____

I understand and agree that any and all of this information may be shared with appropriate school personnel.

_____ _____

Parent/Guardian Signature Date

_____ _____

Signature of Certified School Nurse Date

Mt. Lebanon School District

IMMUNIZATION REQUIREMENTS

408-D (Rev.1/2020)

Pennsylvania and Allegheny County Health department (ACHD) Immunization Requirements per 28 PA Code Chapter 23, Subchapter C, require that all children show proof of immunization **before** they may attend any public, private, charter or home school in the Commonwealth. **Your child will not be permitted to attend school until you have submitted documentation of the required immunizations and they have been received and approved by the Certified School Nurse.**

Students who are entering school are required to have the following properly spaced vaccines:

4 *doses of tetanus, diphtheria and acellular pertussis*
(1 dose on or after the 4th birthday); 3 doses, if series ***started after*** *7 years of age*
- *Usually given as DTP or DTaP or DT or TD -* ***NOT*** *Tdap.*

4 *doses of polio*
(4th dose on or after 4th birthday), or 3 doses if 3rd dose ***started on or after*** *the 4th birthday with proper spacing.*
2 *doses of measles, mumps, rubella (usually given as MMR)*
3 *doses of hepatitis B (properly spaced)*
2 *doses of varicella (chickenpox) vaccine*
- *or written statement from parent or health care professional indicating month/year of disease*
- *or proof of immunity by blood test - giving specific titer*

Kindergarten: Lead testing

Students who are in Grades 7-11 are required to have the following vaccines in addition to the above vaccines:
1 dose of tetanus/diphtheria/pertussis (**Tdap**) (**required at 11-12 years of age**)
1 dose of meningococcal conjugate (MCV4 #1)

Students who are entering **Grade 12** are required to have the following vaccine in addition to the above vaccines:
2nd dose of meningococcal conjugate (MCV4 #2)

EXEMPTIONS

MEDICAL Exemption: If the physical condition of your child is such that immunization would endanger life or health, a medical exemption must be submitted. Only licensed medical doctors and doctor of osteopathy and designated Health Department personnel may waive immunization requirements. ***Chiropractors' certification for medical exemptions are not acceptable by law***. If a medical exemption is for a specific antigen(s) this should be indicated in the statement of exemption. All other immunizations will still be required. These statements of exemption must be written by the appropriate medical personnel and submitted to the Certified School Nurse **prior to your child entering school.**

RELIGIOUS Exemption: This includes a strong or ethical conviction similar to a religious belief. The Certified School Nurse must be notified by the parent in writing of the reasons for this exemption **prior to your child entering school.**

If a child is exempt from immunizations and a vaccine preventable disease outbreak occurs, he/she may be excluded from school per the direction from Allegheny County Health Department.

IMMUNIZATIONS

Allegheny County Health Department immunization clinic offers routine recommended vaccines for children up to the age of 18. Immunizations are FREE of charge for those who qualify. Certain insurances are also accepted at the Allegheny County Health immunization clinic.

Children can receive free vaccines at the Allegheny County Health Department clinic if:

- They are on Medicaid
- They have NO health insurance
- Their health insurance does not cover the cost of vaccines
- They are American Indian or Alaskan native

Immunizations are available without an Appointment. Please call the clinic for open dates & times

Allegheny County Health Department **NEW DOWNTOWN LOCATION:**

Hartley Rose Building(near intersection of 1st Avenue & Cherry Way)
425 First Avenue
4th Floor
Pittsburgh, A 15219
Phone: (412) 578- 8062

Public Transportation access via the Port Authority of Allegheny County:
BUS- 42 Bower Hill Rd., exit BLVD of the Allies & Smithfield Street
Subway (**T stations**) - Red & Blue lines **EXIT** 1st Avenue Station

All others should seek immunization services through their Primary Care Physicians (PCP) office.

Mt. Lebanon School District

Heath Services
7 Horsman Drive
Pittsburgh, Pennsylvania 15228-1107

(4/19;10/19;5/20)

Authorization for Medication

For safety reasons, the administration of student medicines, either prescription or non-prescription, during school hours is strongly discouraged.

If a physician deems it necessary for your child to take medications, either prescription or nonprescription during the school day, the **AUTHORIZATION FOR MEDICATION FORM** (reverse side) must be completed by **both** a parent/guardian and physician and returned to your child's health office prior to any medication being administered.

The following summarizes the procedure:

- ***Physician orders MUST be dated July 1st or after for the upcoming school year***
- *Prescription medication must be in the current and appropriate labeled pharmacy container.*
- *Over the counter medication must be in the original, unopened container and the type of over the counter medication must match the physician's orders.*
- *A new form completed by **both** the physician and parent is required for **each medication,** medication change, dose change and for each new school year.*
- *It is the responsibility of your child to report to the health office for his/her medication.*
- *Emergency medications (Epinephrine Auto injector and/or Rescue inhaler and/or Diabetic Supplies) may be carried by students after completion of:*

Authorization for Medication Form
Self Carry Form

Please remember that your child may not receive his/her medication if these procedures are not followed.

Please feel free to contact your child's school certified nurse if you have any questions or concerns regarding this matter.

Thank you for your cooperation.
Health Service Department

OVER

Mt. LEBANON SCHOOL DISTRICT HEALTH SERVICES

Authorization for Medication, prescription and non-prescription, to be given during school hours

3/18; 4/19; 10/21

Student's Name:_____ ID# _____School_____

Date of Birth_____Sex_____ Grade/Homeroom_____

Physician's Name_____ Office Phone Number_____

TO BE COMPLETED BY LICENSED PRESCRIBER:

MEDICATION	
DOSAGE	
TIME OF ADMINISTRATION	
LENGTH OF ADMINISTRATION (i.e. the school year or a shorter time)	
REASON FOR MEDICATION	
ADMINISTRATION INSTRUCTIONS	
SIDE EFFECTS	
SELF-ADMINISTRATION/SELF CARRY (This student is authorized to self-carry his/her Rescue Inhaler or Auto Injecting Epinephrine and/or Diabetic Supplies and medicate himself/herself.	**YES___ PHYSICIAN'S INITIALS_____** **NO___ PHYSICIAN'S INITIALS_____**
SIGNATURE OF LICENSED PRESCRIBER	
DATE	

TO BE COMPLETED BY PARENT/GUARDIAN:

In consideration of Mt. Lebanon School District granting our request to dispense certain medication to our child and.or allow self-administration of medication, the undersigned parents/guardians, on our own behalf and on behalf of our minor child, hereby release, indemnify and hold harmless Mt. Lebanon School District and its School Board, Administrators, Teachers, Secretaries, Nurses and Employees from and against any and all claims, damages, actions or causes of action resulting and/or arising out of or connected directly or indirectly with the request for or the dispensing of medication listed above to our said child. **I understand and agree the medical information may be shared with appropriate personnel. I authorize my child's physician to release any medical information that may be required by district personnel. I understand and agree that emergency medication may be administered by District employees who are not nurses.**

Parent/Guardian signature_____ Date_____
Home Phone #_____Work #_____Cell #_____

H514.027(8/2011-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 1	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 Exam

_____ _____
Signature of Dental Examiner Print name of Dental Examiner

_____
Address

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 ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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 ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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: *L*	**ABNORMAL*	*DEFER*	***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
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:

#

Mt. Lebanon School District

Electronic Emergency Medical Contact/Release Information Request Update

Dear Parents/Guardians:

Parents/Guardians are required to complete an Emergency Medical Contact/Release Information sheet on their children each year. Please check and update your child's emergency Medical Contact/Release information page on Dashboard, if not already competed. **A review/revision is required every school year as well as anytime a change is necessary.** Each time a review/revision has been made, please click "**SUBMIT**" at the bottom of the screen and save the review/revision.

The Emergency Medical Contact/release information page will be used in the event that your child is ill, injured or there is an emergency. **The Emergency Medical Contact/Release information is requested to ensure the safety and security needs of your children. It is important that the information be as accurate and up to date as possible.**

Please not the following tips:

1. You must go in under the parent/guardian's dashboard account, **NOT** the student's.
2. Emergency Medical Contact/Release information is located under "account preferences tab.
3. Please include parents/guardians (in priority order) as part of your four contact options in you wish to be contacted.
4. Please enter this information for each student—you may utilize the "copy from" feature to expedite the process.
5. **If you have completed this information in a previous year, please review it every school year and event if there are not changes, click the "SUBMIT" at the bottom of the screen. This will complete the process and the information will be saved.**
6. Students with more than one parent account or those who do not have access to a computer will need to complete a hard copy of the Emergency Medical Contact Release Information Sheet. Please contact your child's health office or school secretary for a copy of this.
7. If the Emergency Medical Contact/Release Information Sheet is not competed, there will be a deficiency that shows up on your child's and parent/guardian Dashboard account under the balance icon. This will be cleared once the Emergency Contact/Release Information Sheet is completed and updated. No money is due for this.
8. Please contact your child's health office for any issues, concerns or if you will need a hard copy Emergency Medical Contact/Release Information Sheet.

Thank you for your assistance in completing this vital part of your child's health record.

Health Services Department