Mercersburg Academy Student Health Form
Report of Physical Examination

Student's Last Name _____ First Name _____ Middle Name _____ Date of Birth _____

BP: _____ / _____
Pulse: _____ Resp: _____

Vision Exam
With Corrective lenses ❑
Without Corrective lenses ❑
Right: 20/ Left: 20/

Height (in inches): _____
Weight (in pounds): _____

Hearing Test:
Method: _____
Right: _____
Left: _____

Food, Medication or Other Allergies:

Does the patient require an EpiPen? Yes ___ No ___
If yes, the Health Care Provider is to complete the AUTHORIZATION FOR MANAGEMENT OF ANAPHYLAXIS form on page 2.

Physical Exam: Check "YES" for normal findings or "NO" for abnormal findings. Provide additional information in the spaces provided for any category marked "NO."

NORMAL EXAM?	YES	NO
1. Eyes		
2. Head, Ears, Nose & Throat		
3. Dental		
4. Respiratory		
5. Cardiovascular		
6. Gastrointestinal		
7. Hernia		
8. Genitourinary		
9. Musculoskeletal		
10. Metabolic / Endocrine		
11. Neuropsychiatric		
12. Skin & Lymphatics		
13. Medically eligible for all sports without restrictions		
13a. If no, please provide detailed explanation of activity restrictions or recommendations.		

Care, recommendations and/or any restrictions
* PLEASE PROVIDE PERTINENT CONSULT NOTES/INFORMATION

List all Prescription Medicines ordered for student: (Please include name, dose, & administration instructions)

Immunization Report
Please provide a current immunization record. Please refer to Pennsylvania School Immunization Requirements (page 3).

Tuberculosis (Tb) Screening: To be completed by health care provider and patient. (Please answer all questions.)

	Yes	No
Has a family member or close contact had tuberculosis?		
Has a family member had a positive tuberculin skin test?		
Are you from a high risk country (a country other than the United States, Canada, Australia, New Zealand or Western and Northern European countries)?		
Have you traveled to a high risk country for more than 4 weeks (including school trips)?		

Date of test (if indicated) _____
Results _____

Chest x-ray is required, regardless of BCG status, if TB skin test is greater than 10mm.

Date of x-ray _____
Results _____
Treatment completed? Yes _____ No _____

A PPD skin test for tuberculosis IS REQUIRED ANNUALLY for students who answer YES to ANY of the above questions.

NOTE: History of BCG vaccination does not preclude testing a member of a high-risk group.

Name, Address, and Telephone (please print): _____

Health Care Provider's Signature: _____ Date of Examination: _____

AUTHORIZATION FOR MANAGEMENT OF ANAPHYLAXIS

This order is valid only for the 2019-2020 school year.

Epinephrine auto-injectors are usually administered by the Health Center staff. 911 will be called any time epinephrine is administered.

Name: _____ Date of Birth: _____

HEALTH CARE PROVIDER AUTHORIZATION:

Administer Medication for the Following Allergen(s):

insect sting/bite: _____ ingestion of: _____ contact with: _____

unknown etiology (specify signs/symptoms): _____

Administer the following Medication(s) Immediately:

_____ Epinephrine only

_____ Epinephrine and then adjunct medication(s)

_____ Adjunct medication(s) if no signs or symptoms are present.

- Notify parent/guardian
- Proceed with epinephrine if 1 or more of the following signs/symptoms is seen:
  - LUNG: difficulty breathing, repetitive/hacking cough, audible wheezing
  - THROAT: itching
  - MOUTH/FACE: swelling and/or tingling of lips, tongue, mouth; swelling of eyes
  - SKIN: many hives over the body
  - GUT: diarrhea, stomach pain and/or cramping, vomiting
- A second dose of epinephrine will be administered in 5-10 minutes if EMS has not arrived.

MEDICATION(S) ORDERED:

Epinephrine:	single dose auto-injector	_____ 0.15 mg IM	_____ 0.30mg IM
Adjunct Medication(s):	Diphenhydramine	_____ mg	
	_____	_____	

Possible Medication Side Effects:

Epinephrine: palpitations, rapid heart rate, sweating, nausea and vomiting

Antihistamine: drowsiness, sedation, sleepiness, dizziness, restlessness, hypotension, palpitations

Other: _____

HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name/Title (please print): _____

Address: _____

Phone: _____ Fax: _____

Health Care Provider's Signature _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

I requested designated personnel to administer the medication as prescribed by health care provider above. I certify that I have legal authority to administration of medication at school and understand that the health care provider will be contacted if questions arise regarding the student's medication order.

Signature: _____ Date: _____

Pennsylvania School Immunization Requirements

Pennsylvania State Law requires WRITTEN proof of complete immunization for:

- 4 doses of Tetanus, Diptheria, and acellular Pertussis (If the first dose was given at 16 years of age or older, only one dose is required).
  **1 dose of Tetanus, Diptheria, acellular Pertussis (Tdap) after the age of 11*
- 4 or more doses of Polio vaccine
  *A fourth dose in the routine IPV (inactivated Polio vaccine) is not necessary if the third dose was given at 4 years of age or older and 6 months after the previous dose.
- 2 doses of Measles, Mumps and Rubella
- 3 doses of Hepatitis B
- 2 doses of Varicella (chickenpox) unless student had chickenpox disease in which case approximate year of the disease written by your health care provider
- 2 doses of Meningococcal conjugate vaccine (MCV)*
  First dose is given 11-15 years of age; a second dose is required at age 16 or entry into 12th grade
  *Please make sure that the type of vaccine used prevents 4 types of Meningococcal disease: Groups A, C, Y and W-135

***New Students** should have their Health Care Provider provide them with immunization records in order to complete online forms.*

If immunization is against your religious beliefs or you have strong moral or ethical conviction similar to a religious belief, you must notify the Health Center of this in writing. If there is a medical contraindication; i.e. such that the immunization would endanger the life or health of your child, please provide a statement from your medical care provider stating the problem / reason.

RECOMMENDATION:

Centers for Disease Control (CDC's) Advisory Committee on Immunization Practices (ACIP) recommends vaccination for HPV (Human Pappillomavirus) of both females and males. The HPV vaccine is known to prevent certain HPV related cancers. Please discuss the vaccine with your medical care provider at your physical exam.