TRINITY AREA SCHOOL DISTRICT
ELEMENTARY SCHOOLS

Dear Parent/Guardian,

Welcome to Kindergarten! Our school nurses have a very important role in the process of getting your child registered for school. The following information is vital for our school nurses' in making sure your child's health information is complete.

1. A list of the state required immunizations that your child will need to begin school. Please provide a record of your child's immunizations ***no later than June 1.***
2. Complete the health history form. Please fill the form out completely and accurately. The school nurse needs to have a clear understanding of any medical issue your child has. This allows the school nurse give your child the best care possible.

3. If your child will need to take medications at school daily or on an as needed basis please read the Summary of Medication Policy and complete the *Physician 's Authorization for Administration of Medication During School Hours* form. You can either return or fax the completed form to the appropriate school nurse.

4. You have a blank copy of the Physical and Dental examination forms. Pennsylvania state law requires that any child registering for Kindergarten or 1st grade must have these forms completed by their physician and dentist. You can either return or fax the completed form to the appropriate school nurse. If you do not have access to a physician and/or dentist your school nurse will notify you of the date when these professionals will be at the school to complete a screening to meet the state requirements.

We look forward to meeting you and your child. Please feel to call us at any time with questions you may have. Our names and phone numbers are listed below.

Amanda Gaiser, RN, BSN, CSN
Certified School Nurse
Trinity West Elementary
1041 Gabby Avenue
Washington, PA 15301
724-222-4730 x 1503
Fax: 724-222-0180

Bea Bebout, RN, BSN, CSN
Certified School Nurse
Trinity South Elementary
2500 South Main Street Ext.
Washington, PA 15301
724-225-7490 x 3503
Fax: 724-228-7658

Christy Frazier, RN, BSN, CSN
Certified School Nurse
Trinity North Elementary
225 Midland Drive
Washington, PA 15301
724-222-5064 x 2503
Fax: 724-229-1031

Margaret Drezewski, RN, BSN, CSN
Certified School Nurse
Trinity East Elementary
252 Cameron Road
Washington, PA 15301
724-225-8140 x 4503
Fax: 724-225-4951

TRINITY AREA SCHOOL DISTRICT
231 Park Avenue
Washington, PA 15301
Phone: 724-223-2000

In order to protect children from epidemics of serious and sometimes fatal Diseases, Pennsylvania State Law requires that each child entering school for the first time be ***required to have the following immunizations by the first day of school***.

- 4 doses of the tetanus vaccine* (1 dose on or after the 4th birthday)
- 4 doses of the diphtheria vaccine* (1 dose on or after the 4th birthday)
- 3 doses of the polio vaccine
- 2 doses of the measles vaccine**
- 1 dose of the mumps vaccine**
- 1 dose of the rubella (German measles)**
- 3 doses of the hepatitis B vaccine
- 2 doses of varicella (chickenpox) vaccine or proof of history of the disease

* Usually given as ***DTP, DTaP, DT, or Td***

** Usually given as ***MMR***

It is your right to elect not to immunize your child(ren) due to a medical or religious exemption. Please see the nurse in your child's building for the written release.

Medication Administration Consent And Licensed Prescriber Order

Trinity Area School District

Student Name: _____ Date/Time: _____

School: _____ Teacher/Grade: _____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber. All medications must be in an original prescription bottle/container from a pharmacy.

Parent/Guardian Consent:

I give my permission for my child, _____, to receive the following medication by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name printed: _____ Phone: _____

Licensed Prescriber Medication Order:

Patient's name: _____ **Date:** _____
Name of medication: _____
Route and dosage: _____
Time of administration: _____
Directions: _____
_____
Discontinuation date: _____
Allergies: _____

Licensed prescriber signature: _____

Licensed prescriber name printed: _____ **Phone:** _____

TRINITY AREA SCHOOL DISTRICT
231 PARK AVENUE
WASHINGTON, PA 15301
(PRESCRIPTION MEDICATION)
PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION DURING SCHOOL HOURS

_____ ____ enrolled in Grade ____ at Trinity _____
(Name of Student) (Age) (Elementary, Middle, High School)

must receive the medication listed below during school hours. The particulars related thereto are as follows:

Name of Medication/Prescribed Dosage _____

Time(s)/Length of Time of Administration
(Number) (Days/Weeks) _____

Reason for Administration/Need to Administer During
School Day (Unless specifically stated herein and
supported by reasons for said conclusion, it will be
presumed that the administration of the medication
set forth above is not necessary for the child to
participate in school programs and failure to so
administer said medication will not substantially
limit or prohibit participation in or access to an
aspect of the student's school program.) _____

Other Medications Being Taken or
Prescribed/Possible Side Effects/Allergies _____

Additional Recommendations or Comments _____

Dated: _____ _____
(Signature of Physician)

TO PHYSICIAN: IT IS ESSENTIAL THAT THE REASON FOR ADMINISTRATION, THE NEED TO ADMINISTER DURING THE SCHOOL DAY, AND THE IMPACT THAT FAILURE TO PROVIDE SAID MEDICATION WOULD HAVE ON THE STUDENT BE COMPLETELY STATED IN THIS AUTHORIZATION. **IF INHALER, MUST IT BE CARRIED BY STUDENT?**

PARENTAL PERMISSION FOR ADMINISTRATION OF
MEDICATIONANDRELEASEANDWAIVEROFLIABILITY

We/I do hereby authorize the Trinity Area School District, its agents and employees to administer the medication set forth in the Physician's Authorization above in the manner described above to:

_____ _____
(Full Name of Student) (Address of Student)

and further do hereby release, discharge and hold harmless the Trinity Area School District, its agents and employees, from any and all liability and claim whatsoever for the administration or failure to administer the above medication to the aforesaid student including any allergic or other reaction from the medication set forth above. **If an inhaler**, **We/I do/do not authorize student to retain inhaler.**

We/I acknowledge that we are required to comply in all respects with Policy No. 210 of the Trinity Area School District known as Administration of Medication During School Hours, a summary of which is attached hereto and incorporated by reference herein and that in the event the student is authorized to self-administer medication, that said privilege may be withdrawn and action taken against said student for violation of this and other policies of the school district.

Date: _____ _____ _____ _____
(Witness) (Signature of Parent/Guardian) (Phone No. Work/Home)

Date: _____ _____ _____ _____
(Witness) (Signature of Parent/Guardian) (Phone No. Work/Home)

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 ☐**

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)

H514.027

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		D M D F		

ADDRESS

No. and Street | City or Post Office | Borough or Townshtp | 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	jQ 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 D NoD

Treatment Completed Yes D NoD

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address

Trinity Area School District Homeless and Foster Care Student Liaison Contact and Information

Mr. Donald L. Snoke
231 Park Avenue
Washington, PA. 15301 724-223-2000 ext. 7111
snoked@trinitypride.org

Trinity Area School District Enrollment Secretary
Mrs. Carolyn Miller 724-223-2000 ext. 6510
cmiller4@trinitypride.org

Trinity Area School District Homeless Student Policy 251
https://www.boarddocs.com/pa/tasdpa/Board.nsf/Public#

Most Frequently Asked Questions Educational Rights of Homeless Children
http://www.naehcy.org/sites/default/files/dl/legis/2016-09-16_FAQ_FINAL.pdf

Washington County and Region 4 Services and Contacts http://www.education.pa.gov/K-12/Homeless%20Education/Pages/Region-4.aspx

Educational Rights Poster for Students http://www.education.pa.gov/Documents/K-12/Homeless%20Education/Homeless%20Poster%20Youth%20English.pdf

Educational Rights for Parents and Guardians http://www.education.pa.gov/Documents/K-12/Homeless%20Education/Homeless%20Poster%20Parent%20English.pdf

Pennsylvania's Education for Children and Youth Experiencing Homelessness Program – State Plan
http://www.education.pa.gov/Documents/K-12/Homeless%20Education/ECYEH%20State%20Plan%202013%20FINAL.pdf

Pennsylvania Department of Education Nutrition Plan and Free Lunches
http://www.education.pa.gov/Documents/K-12/Homeless%20Education/FreeLunchProcedures.pdf

United States Department of Education McKinney Vento Act as amended by ESSA
https://www2.ed.gov/policy/elsec/leg/essa/160240ehcyguidance072716.pdf

United States Department of Education McKinney Vento Act Fact Sheet
http://uscode.house.gov/view.xhtml?path=/prelim%40title42/chapter119/subchapter6/partB&edition= prelim