In order to give more satisfactory educational and health services to your child, please complete this form and return it to the school.

Child's Name _____ Date of Birth: _____

Parent's Name _____

Address _____ Home Phone _____

Student Lives with: Both Parents _____ Mother Only _____ Father Only _____ Other _____ Relationship

Father's Place of Employment _____ Work Phone _____ Cell # _____

Mother's Place of Employment _____ Work Phone _____ Cell # _____

In case of an accident or illness in school and the above can not be reached, list individuals you would allow to care for and transport your child.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name of family physician _____ Name of family dentist _____

Any Serious Health Conditions/Concerns/Allergies you want to make us aware of: _____

_____

_____

I DO _____ I DO NOT _____ authorize the Meyersdale Area School District to give first aid, if necessary during the school day. I hereby authorize the school to transport, or to make arrangements for the transportation of my child to an emergency care facility, and to sign permission for the medical treatment declared immediately necessary by the physician or dentist, in the event that the persons listed above cannot be contacted. It is understood that your reaction to this form will be in effect during the remainder of your child's enrollment in the Meyersdale Area Schools. **For any changes, please contact the school nurse.**

_____

Parent or Guardian Signature Date

OVER

List any information about your child you feel the school should be aware of: (example: hearing, vision, and emotional problems; hyperactivity, a physical handicap, asthma, or is currently taking prescription drugs).

_____

_____

FIRST AID PRACTICE

The following are Meyersdale Area Schools standing FIRST AID orders and medications available for your child at school which were prescribed by the school physician.

Beestings: Bee Sting Ease or Ice to the area.
Minor Wounds: Cleanse the area with soap & water & apply Bacitracin/ Triple Antibiotic/ apply Bandage if needed.
Abrasions, Lacerations, Wounds or Infected Areas: Cleanse the area with soap & water and apply Neosporin/Bacitracin/Triple Antibiotic & apply a dry dressing
Minor Eye Irritations: Irrigate with eye irrigating solution and/or saline.
Recent Injuries & Burns: Soak or rinse with cold water or water, apply burn gel/spray with lidocaine. If pain due to injury or inflammation related injury – Ibuprofen 200 – 400mg.
Epistaxis: Apply pressure to nose.
Headache: Apply ice pack and rest.
Severe Headache: Children 12 yrs of age and up, give either 2 tabs of 325mg or 500mg Tylenol
Children 9-12yrs give 1 tablet of 325mg Tylenol
Children under age 9yrs give liquid/chewable tablets of Tylenol according to age & wgt.
Cold Sore, Fever Blisters: Anbesol Gel or tums paste.
Mouth Ulcers, Irritated Gums: Salt water rinse and/or chol spray /tums paste/anbesol
Indigestion, Upset Stomach or Nauseated: Maalox Tablets/Tums-Rest
Insect Bites, Stings, Rashes and Skin Irritations: Hydrocortisone Cream 1% For painful stings an external anesthetic containing benzocaine will be applied or Callergy Lotion
Earache: Cotton in ear if drainage is present.
Severe Earache: Children 12 years of age or older-2 tabs of 325mg or 500mg Tylenol
Children 9- 12yrs, 1 tab 325mg Tylenol.
Children under 9 years give liquid/chewable tablets of Tylenol according to age and wgt
Menstrual Cramps: Warm water bottle to abdomen and rest.
Severe Menstrual Cramps: Children 12yrs and older, give 2 tabs of 325mg or 500mg Tylenol
Children 9-12years 1 tab 325mg Tylenol or Ibuprofen 200 to 400 mg if preferred.
Sore Pierced Ear lobes-other pierced areas: Cleanse area with alcohol.
Sore/ Irritated Throat: Chloraseptic Oral Anesthetic Spray and/or Cough Drops.
Cough: Cough drops/ Throat Lozenges (not given to kindergarten students)
Toothache: Warm water rinse-anbesol gel or chloraseptic spray.
Severe Toothache: Children 12yrs or older-2 tabs 325mg or 500mg Tylenol
Children 9-12yrs 1 tab 325mg Tylenol.
Children under 9yrs give liquidor chewable tablets of Tylenol according to directions.
Chapped Lips – Vaseline / Blistex / or Ointment for Chapped lips
Allergic Reaction: Liquid or Tablet Benadryl –dose according to age and weight.
Life Threatening Anaphalaxis: Epi Pen or Epi Pen Jr. according to weight.
Suspected Drug (Opiod) Overdose: 4mg Naloxone in 0.1ml intranasal spray to any individual suspected of opiod overdose. May repeat every 2-3 minutes if available, until person responds, or EMS arrives.

Non-prescription cold & cough medication must be requested and provided by the parent /guardian in the original container with a written consent. Please note: If you prefer your child take Advil or Ibuprofen-please take this medication into the nurse with a medication consent permission slip.

I give my consent for the above medications and treatments to be rendered to my child as his or her condition warrants, under the supervision of the School Nurse, Sub Nurse, Principal, or his Designee. I understand that the school or staff can, in no way, be held responsible for any condition resulting from such medications & treatments. I am also aware the health information concerning my child will be shared with appropriate staff to ensure the safety and well being of my child.

****

_____

Parent/Guardian Signature **Date**

Meyersdale Area School District: STUDENT HEALTH INFORMATION

Name_____ _____ _____ Birthdate_____ ( ) Boy ( ) Girl
Last First Middle

Child's Doctor's Name_____ Date of Last Exam_____
Child's Dentist's Name_____ Date of Last Exam_____

If your child has allergies or asthma it is the parent's responsibility to notify the nurse and to PROVIDE the inhaler or Epi Pen for use at school EACH year along with the appropriate forms which are available in the nurse's office.

Does child have allergies? ( ) Yes ( ) No
Please list_____
Has the allergy required any emergency action in the past?
( ) Yes ( ) No
Comments:_____

Bee Sting Allergy? ( ) Yes ( ) No
Describe reaction_____
Difficult breathing? ( ) Yes ( ) No
Need emergency medication? ( ) Yes ( ) No

Asthma? ( ) Yes ( ) No
Triggered by_____
Treatment_____
Diagnosed by doctor_____ Date_____

Diabetes? ( ) Yes ( ) No
Date diagnosed_____
Comments_____

Epilepsy/Seizures? ( ) Yes ( ) No
Describe seizure_____
Date of last seizure_____
Medication_____

Heart Condition? ( ) Yes ( ) No
Describe_____
Any restrictions_____
Medications_____

Bone/Muscle/Joint Problem? ( ) Yes ( ) No
Describe_____
Any physical restrictions_____

Check off any of the following health concerns that pertain to your child:

Eyes: Glasses
( ) Reading ( ) Contacts ( ) Difficulty Seeing
( ) Distance ( ) Crossed ( ) Lazy Eye

Ears:
( ) Hearing Aid ( ) Left ( ) Right
( ) Frequent Infections
( ) Tubes
( ) Hearing difficulty, explain_____

Other: ( ) Nosebleeds ( ) Headaches ( ) ADD/ADHD ( ) Neurologic ( ) Phobias ( ) Blood Disorder
( ) Special physical care needed_____

Daily medication at home? ( ) Yes ( ) No At school? ( ) Yes ( ) No Emergency only? ( ) Yes ( ) No
If Yes to medications at home – name of medication_____
List serious illnesses, surgeries or injuries_____

List any other information/condition/concern you want to call to our attention_____

If child requires medication/care at school, please ask the nurse for the necessary form.

Signature of Parent or Legal Guardian_____ Date_____

Meyersdale Area School District

PERMISSION TO SHARE HEALTH INFORMATION

Student Name:_____
First Last

Date of Birth:_____

I, _____, give permission to the Meyersdale Area School District to communicate either verbally or in writing any medical condition or student information related to classroom behaviors or observations (including lists of students/athletes) shared by me or as a result of an examination. Examinations would include: athletic physical examination, mandated physical examinations, dental examinations and immunization records.

This information may be communicated to the following personnel: **(Please cross out any you wish to exclude)**

School administrators
Athletic directors
Athletic trainers
Coaches
Teachers/substitute teachers
~~Cafeteria Staff~~ (i.e. ~~food allergy~~)
Bus Drivers (i.e. bee sting allergy or seizures)
nurse/ substitute nurse
school/team physicians
health services/school dentist
family doctor/dentist
counselors
~~secretaries~~
BSC/TSS Staff(Behavioral Support Services)

Please understand that the information is used by school employees only to provide for the health, safety, and well being of the student.

This consent is valid for the duration of enrollment for the above mentioned student, unless revoked by written notification, in the interim.

I acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. ALL information will be handled confidentially in compliance with the Federal Privacy Act.

_____
Signature of Parent of Guardian

_____
Date of Authorization

THIS FORM MUST BE RETURNED TO THE SCHOOL NURSE

Meyersdale Area School District: **PHYSICAL and DENTAL EXAMINATIONS**

The Rules and Regulations of the Commonwealth of Pennsylvania Department of Health mandate both a physical examination and a dental exam upon original entry into school and for students transferring from out of state. The physical exam is also required for sixth grade and eleventh grade. The dental exam is required for students in third grade as well as seventh grade.

You may choose to have the examinations done by your family doctor/dentist or by the school doctor/dentist.

If you want your family doctor/dentist to do the examination, it must be recorded on a form provided by the school. Any examination done up to one year prior to the opening of school, or by October 31 of the present school year will be accepted as the required examination for school. Payments for these exams are the responsibility of the parents.

If you choose the school doctor and/or dentist the exam will be provided to you at no cost. The physical examination is very general- the heart, lungs, skin, eyes, ears, nose, throat, abdomen, neuromuscular system and general nutrition are addressed. A hernia/testicular exam could possibly be done on the boys. Any questionable results will be reported to the parents. If you prefer you may be present during either exam-please contact the school nurse if you want to be present.

Please sign your preference for your child's physical examination as well as your preference for his/her dental exam and return the bottom portion of this form to the school.

Amy Rough
School Nurse

Complete Both Sections

[ ] I will have the medical examination done by my family physician and return the form provided by the school no later than October 31st.

[ ] I prefer to have my child scheduled for a medical examination by the school physician.

[ ] **The school doctor has my permission to examine my child in school, if I have not returned the report from my family doctor.**

[ ] I will have the dental examination done by my family dentist and return the form provided by the school no later than October 31st.

[ ] I prefer to have my child scheduled for a dental examination by the school dentist.

[ ] **The school dentist has my permission to examine my child in the school, if I have not returned the report from my family dentist.**

Student's Name_____

Signature of Parent/Guardian_____ Date:_____

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 t 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 _____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

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: NORMAL	*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 ☐

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

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)					

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 19____

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

ADDRESS

No. and Street | City or Post Office | Borough or 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

** Please be Aware**
Meyersdale Area School District
no longer provides Fluoride

This form MUST be COMPLETED before any prescribed medication will be given to your child. It is your responsibility to have your child's physician complete this form. This is a Health Department Regulation. If your child has a change in dose or time this form needs completed again. Medications will not be accepted unless this form accompanies it. Our Fax# 814-634-0832

MEYERSDALE AREA SCHOOL DISTRICT

ADMINISTERING MEDICATION TO STUDENTS

PARENT'S REQUEST

I/We hereby request that the Meyersdale Area School District, through its appropriate personnel, administer a physician's prescribed medication to my/our child as described below. I/We further hereby release and hold harmless, the Meyersdale Area School District and its employees , from any liability, injury or damages as a result of such administration of medicine.

Parent/Guardian Signature_____

Please Initial here is your child was prescribed an inhaler and you feel they are responsible to carry it with them and self medicate if necessary. _____

DOCTOR'S REQUEST

Consistent with the above request by the parents of the child identified below, I hereby request that the Meyersdale Area School District allow its appropriate personnel to administer a medication which I have prescribed as follows:

Child's Name_____

Diagnosis_____

Name of Medication_____

If an inhaler has been prescribed please see extra initial requirement for self medication below physician signature area.

Dosage_____

Time to be Administered_____

Possible Side Effects to watch for_____

_____

Termination Date_____

_____ _____

Date Physician's Signature

Please initial here if you have prescribed an inhaler and you feel this child can safely carry the medication on their person and self medicate when necessary. _____.

MEDICATION PROCEDURES

In accordance with the Pennsylvania Department of Health's Guidelines for the Administration of Medications the following procedures shall be followed when medication must be administered to students during school hours:

ALL MEDICATIONS MUST be accompanied by a consent form from the **parent** *and* the **physician**. The consent form is available in the nurse's office. All physicians in the surrounding areas have received instruction and a blank copy to have on hand for our students. I understand it is difficult to remember to ask for the form but all parents must be in compliance with this regulation. Keep a blank copy in your car, purse, or wallet to have on hand. Talk to your physician about options to medication schedules if it will be a hardship for you to follow these requirements. Talk to your pharmacist in obtaining an extra bottle if needed for you to have one at home or for example in regard to liquid antibiotics, most pharmacies will distribute medication into 2 properly labeled bottles one for home and one for school if you ask.

Any medication to be given during school hours must be delivered directly to the school nurse. The medication must be brought to school in the original pharmaceutically-dispensed and properly labeled container. Consent forms for medications must be signed by the ordering physician and the parent/guardian before the medication will be given to your child.

Homeopathic Remedies and Herbal Preparations, Enzymes, Vitamins and Minerals are referred to as Complimentary and Alternative Medicine (CAM) and in school are treated as prescription medications requiring a **licensed prescriber's order** *and* parent/guardian permission/consent. A chiropractor is not a licensed prescriber.

The nurse is able to give "Standing Order" medications to your child since the school doctor has given consent for those medications. Tylenol, Tums, Triple Antibiotic cream etc are still available for your child to have at school if their condition warrants.

If your child does receive a daily medication, in the event that the school nurse is absent and a nurse substitute is unavailable, you will be notified to see if you want to come give your child their medication.

If you have any questions or concerns regarding these guidelines please call the school nurse at (814)634-8311 ext 308.

Your child's doctor's office may benefit from having our fax number as well for future use: (814) 634- 0832.

Thank you,

Amy Rough BSRN
School Nurse