

## Avonworth Primary Center

1310 Roosevelt Road  
Pittsburgh PA 15237  
412-366-7171  
www.avonworth.k12.pa.us

Dear Kindergarten Parents and Guardians,

Welcome to Avonworth School District! We look forward to meeting your new kindergartener! Before the first day of school, there are a few things with which we need to make you familiar.

School Law of the Commonwealth of Pennsylvania requires physical and dental examinations for children upon entry into school. It is strongly recommended that your private physician and dentist perform these examinations as part of your child's yearly well-child visits. Attached are the forms to be filled out by the physician and dentist and returned to the school nurse **before the first day of school**. Exceptions may be made because of insurance coverage of physicals and birthdates of the child. Please discuss this with the nurse if your form cannot be completed by the first day of school. If you cannot afford these examinations, or need information on free health insurance coverage, please contact the school nurse.

**Proof of immunization is required upon registration.** Please review the immunization regulations provided and contact the school nurse if you have any questions. The nurse must have documentation of **ALL** required immunizations **BEFORE** the first day of school.

***Your child will NOT be permitted to attend on the first day of school if immunizations are incomplete.***

Complete the health history form and turn this in at registration. Please contact the school nurse if your child has any health problems or special needs. (severe allergies, diabetes, seizures, asthma, etc.) We are looking forward to caring for your child. To provide the best possible care we need to work as a team. The more informed we are about your child the better care we can give them. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

Mara Alterio, MSN, Certified School Nurse  
malterio@avonworth.k12.pa.us

**Phone:** 412-366-7171 X1906 or X1812

**Fax Number -** 412-548-3324

# Welcome to Avonworth Primary Center!

## Health Information Checklist for Kindergarten Registration

All of the forms listed below can be printed by clicking the links below.

- [Immunizations](#) - due at registration  
\*Immunizations must be **complete BEFORE** the first day of school!!!
  
  - [Health History Form](#)  
\*\*Completed by parent - due at registration  
\*\*Contact the school nurse if your child has health issues  
(severe allergy, asthma, seizures, etc.)
  
  - [Physical Exam Form](#)  
\*\*Completed and signed by health care provider and dated after July 1, 2025
  
  - [Dental Exam Form](#)  
\*\*Completed and signed by dentist and dated after July 1, 2025
- \* [Medication Procedure](#) & [Order Form](#)  
\*\*Included for your information - notification of district medication procedures  
DO NOT return unless your child will require medication during school hours



*Mara Alterio*, Certified School Nurse

[malterio@avonworth.k12.pa.us](mailto:malterio@avonworth.k12.pa.us)

412-366-7171 x 1906

# School Vaccination Requirements

For Attendance in Pennsylvania Schools

Children in ALL grades need the following **BEFORE** the first day of school:

★ **4 doses of tetanus, diphtheria, acellular pertussis (DTaP)**

- 4th dose on or after 4th birthday and at least 6 months after previous dose

★ **4 doses of polio**

- 4th dose on or after 4th birthday and at least 6 months after previous dose

★ **2 doses of measles, mumps, rubella (MMR)**

★ **3 doses of hepatitis B**

★ **2 doses of varicella (chickenpox)**

- If all of the above are not complete and are medically appropriate they must be completed within the first five days of school.
- If the above will not be complete (for medical reasons) before the start of school a medical plan must be signed by a physician and be returned to the nurse. This plan must include the dates of when the missing immunizations will be given.
- The medical plan must be followed or risk exclusion.

## AVONWORTH SCHOOL DISTRICT – STUDENT HEALTH HISTORY

Name:	Sex: M / F	Date of Birth:
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I. <b>**LIFE THREATENING CONDITIONS**</b>		<b>**Emergency Action Plan required**</b> (request from nurse)	
YES	NO	Does your child have:	Provide details for any YES answers
		Severe allergies?	Specify allergens: Typical symptoms:
		Prescribed auto injecting epinephrine?	(must be provided to nurse)
		Severe Asthma ( <b>regularly</b> takes asthma medication and/or hospitalized within the last 5 years for an asthmatic condition)	
		Diabetes	Type: _____ Year of diagnosis: _____
		Seizure Disorder requiring emergency medication	Type: _____ Year of diagnosis: _____ Last Seizure: _____ Medications: _____

***\*\*Please note: Information on urgent health conditions may be shared with staff for safety purposes\*\****

II. <b>SPECIAL HEALTH NEEDS</b>			
YES	NO	Does your child:	Provide details for any YES answers
		Have a history of serious illness or surgeries?	
		Have any allergies not listed above?	
		Need to take any medication at school?	
		Follow a special diet?	
		Have any toileting issues?	
		Have any hearing loss?	
		Have any vision problems?	
		Have any other health needs of which the nurse should be aware?	

**\*\*\*If your child requires medication in school, a written physician's order is required. No medication may be carried in school by a student; this includes "over-the-counter" medications. All medication must be delivered to the Nursing Office by a parent/guardian with the physician's original order and written parental permission. See attached Medication Procedures. Contact the School Nurse to discuss any health issues prior to the start of school. This information is necessary to assist the nurse in meeting your child's school health needs. All information is confidential but may be shared on a "need to know basis" to ensure your child's safety. Please contact the building nurse to discuss health issues prior to the start of school\*\*\***

IV. HEALTH HISTORY		Provide details for any YES answers	
YES	NO	CONDITION	DETAILS
		Attention Deficit: ___ADD or ___ADHD Date Diagnosed: _____ Meds: <b>YES / NO</b>	
		Asthma / Reactive Airway <ul style="list-style-type: none"> <li>• Will your child require an inhaler or nebulizer at school? <b>YES / NO</b></li> <li>• <b>If YES-Fill out Action Plan</b> (request from nurse)</li> </ul>	
		Autism / PDD	
		Arthritis / rheumatic Disease	
		Behavioral / emotional concerns	
		Birth / pregnancy complications	
		Bleeding Disorder	
		Bowel / digestive problem	
		Cancer, Type: _____ Date of diagnosis →	
		Cerebral Palsy	
		Cleft lip / palate	
		Cystic fibrosis	
		Dental problems	
		Growth problem	
		Heart problem specify →	
		Hernia	
		High blood pressure	
		Hospitalizations specify →	
		Immunodeficiency disease	
		Kidney / urinary problem	
		Lyme disease	
		Muscular disorder	
		Migraine headaches	
		Nutritional / weight problem / eating disorder specify →	
		Orthopedic problem (bone / joint)	
		Scoliosis / abnormal spinal curve - Date of diagnosis & last evaluation →	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Tics or twitches	
		Other	
		<b>My child has no special health needs or concerns</b>	Parent/Guardian initials:

I understand & agree that if my child's health status changes during the school year, I will notify the Nursing Office. I have read & understood the above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



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: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	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: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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 <b>DURING</b> or <b>AFTER</b> exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	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: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	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. <b>FEMALES ONLY:</b> Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	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: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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 PERFORMING EXAMINATION: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Physical exam for grade:  K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	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 <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/>
Physical exam performed at: Personal Health Care Provider's Office <input type="checkbox"/> School <input type="checkbox"/> Date of exam _____ 20____
Print name of examiner _____
Print examiner's office address _____ Phone _____
Signature of examiner _____ MD <input type="checkbox"/> DO <input type="checkbox"/> PAC <input type="checkbox"/> CRNP <input type="checkbox"/>

**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 <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	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
<b>Other Vaccines: (Type and Date)</b>					

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
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last	First	Middle				

ADDRESS

\_\_\_\_\_  
No. and Street      City or Post Office      Borough/Township      County      State      Zip

**REPORT OF EXAMINATION**

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	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

# **AVONWORTH SCHOOL DISTRICT MEDICATION PROCEDURES**

Medications brought to school that do not meet the following requirements will not be given.

## **Prescription Medications**

- Nurses in Pennsylvania cannot administer **ANY** medications without a doctor's order and parent/guardian permission.
- **Medication Administration Form** is required for each medication and must be signed by a parent/Guardian and prescribing doctor.
- Prescription medications must be in the original pharmacy container or packaging with a pharmacy label on the package.
- Medications that are not in labeled original containers are not acceptable and will be disposed of immediately.
- Medications must be delivered directly to a nurse by an adult. Students are not permitted to carry medication in school or on the bus with the exception of emergency medications with proper documentation.
- New medication orders and forms are required at the beginning of each academic year.
- Medications left in the health office at the end of the school year will be discarded unless picked up by parents.
- Expired and discontinued medications will be disposed of appropriately unless picked up by parents.
- Parent/guardian is responsible to inform the nurse of any change in medications.

## **Non-Prescription Over-the-Counter (OTC) Medications**

- The School Physician has provided a doctor's order for the school nurse to administer Acetaminophen, Ibuprofen or Tums to students during school hours at the discretion of the School Nurse.
- All non-prescription medications other than Acetaminophen, Ibuprofen or Tums require a **Medication Administration Form** signed by the doctor and parent/guardian.
- Parents/Guardians must provide digital or written permission for Acetaminophen, Ibuprofen or Tums to be administered by the nurse during school hours. OTC medication will **NOT** be given without digital or written parent/guardian permission.
- All OTC medications must be in the original labeled container.
- **For primary/elementary students:** The above OTC medications will only be given after communication with a parent/guardian or as arranged between nurse and parent/guardian.

**Students are not permitted to carry ANY medications without a waiver while at school including prescription and over-the-counter medications, vitamins, and supplements.**

Strict adherence to this policy is necessary for the safety of all students, and to protect your child and yourself from responsibility should these medications fall into the hands of another student on the bus or school property.

## Emergency or Chronic Disease Medications

- Includes all medications used to treat severe allergic reactions, anaphylaxis, asthma, diabetes, seizures, etc.
- It is the responsibility of the parent/guardian to deliver these medications to the nurse on or before the first day of school.
- Parents/Guardian must provide a Medication Order Form and Emergency Action Plan to the nurse for students with asthma, severe allergies, seizures, or diabetes before or at the start of the school year. (Available in the health office or on the website).
- These medications must be kept in the health office at all times unless a student has a completed and signed waiver on file in the health office.
- In accordance with Pennsylvania state law, students with severe or unstable illnesses may carry certain medications (epinephrine autoinjectors, inhalers, diabetes medications) at school or on the bus. If a student is unable to self-administer a medication, parents may opt to make special arrangements with the transportation company. Students must demonstrate responsible behavior in using the medication. Failure to do this will result in withdrawal of permission to carry and use medication.
- For students in grades 7-12, in lieu of a licensed prescriber statement, the nurse, in collaboration with parent/guardian, may make a determination that the student is competent to self administer.
- It is the responsibility of the parent/guardian of students with asthma, severe allergies, or other chronic conditions possibly requiring medication/treatments outside of school hours to make arrangements with the supervisors of those activities.
- Please note that to ensure the safety of your child, basic information regarding life-threatening and emergency conditions may be shared with staff interacting with your child. If you wish for this information to be withheld you must let the building nurse know in writing.

## Field Trips During School Hours

- Administration of non-emergency/daily medication on a field trip will be addressed with the parent/ guardian on an individual basis. Be sure the field trip section of the *Medication Order* form is completed by the prescriber.

**AVONWORTH SCHOOL DISTRICT**  
**Medication Order for Administration in School**

To be completed by licensed prescriber:

Date: \_\_\_\_\_

<b>Student's Name:</b> _____		<b>Grade/Homeroom:</b> _____	
<b>Medication Name</b>	<b>#1</b>	<b>#2</b>	
<b>Dosage &amp; Route</b>			
<b>Time of Administration</b>			
<b>Length of Administration</b>	Start Date _____ Stop Date _____	Start Date _____ Stop Date _____	
<b>Reason for Medication</b>			
<b>Administration Instructions</b>			
<b>Side Effects</b>			
<b>Field Trips</b>	<p>Please <u>check one</u> of the following options when a parent/guardian or parent/guardian designee (non-staff) is unable to attend a field trip:</p> <p>_____ Yes, the prescribed dose can be withheld on the day of the field trip.</p> <p>_____ Yes, the time can be adjusted with a parent to be administered upon return to school.</p> <p>_____ No, this medication must be given to the child at the prescribed time.</p> <p>Explain: _____</p>		
<b>Competency for Self Administration</b> <small>(ONLY for inhaler or auto-inject epinephrine)</small>	<p>I, _____, certify that this student has a potentially life threatening illness and  <small>(licensed prescriber's printed name)</small>  requires an inhaler or auto injecting epinephrine. This student is competent and has been instructed in the proper method of self administration of said medication. This student may therefore carry and self-administer his/her inhaler or auto injecting epinephrine.</p>		
<b>Signature of Licensed Prescriber</b>	<p>_____ Phone: _____  <small>(Not valid without licensed prescriber signature)</small></p>		

**To be completed by Parent/Guardian:**

I give permission for my child to receive the above noted medication at school. I waive and release the District and any District employee from any and all liability or responsibility for the administration of the medication or benefits or consequences of the medication and acknowledge that the District bears no responsibility for ensuring that the medication is taken. I also give my permission for the school nurse to contact the licensed prescriber, as necessary, regarding the medication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Not valid without signature)

**If there is a two hour delay of opening school:**

- \_\_\_\_\_ Yes, administer my child's medication as prescribed
- \_\_\_\_\_ No, I will contact you if the time is to be adjusted