



New Student Registration Health Packet

Dear Parent:

The following documents are required to register your child in Peters Township:

- A completed current immunization report (which may be obtained from your physician).

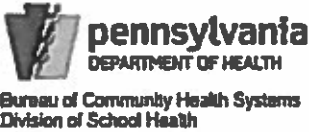
Please note that proposed Pennsylvania regulations state that all children are required to be fully immunized to attend school.

- Students missing the next or final dose of a vaccine have five school days to obtain the next or final dose in the series before being excluded from school.
- A student needing more than one dose of a multiple-dose vaccine series may attend school provisionally upon submission of a medical certificate outlining the dates of additional vaccinations. Students will be excluded from school if vaccinations are not submitted according to the timelines.
- A completed copy of the Health History Form (form provided).

In addition, the documents outlined below **MUST** be submitted during the 2017 calendar year as required by Pennsylvania School Code:

- A completed physical examination form (form provided, must be completed by your physician).
- A completed dental examination form (form provided, must be completed by your dentist).
- If your child has already seen a doctor or dentist in 2017, please have them complete these forms and bring them with you to registration.

These completed documents may be scanned and uploaded through the online registration portal. Hard copies will also be accepted. Please contact the school health office with any additional questions you may have. Thank you.



**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: <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: 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: <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 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? <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: 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: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndromes <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 No

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 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						
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td						
Polio Type: OPV or IPV						
Hepatitis B (HepB)						
Measles/Mumps/Rubella (MMR)						
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____					
Varicella Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>						
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella						
Meningococcal Conjugate Vaccine (MCV4)						
Human Papilloma Virus (HPV) Type: HPV2 or HPV4						
Influenza Type: TIV (injected) LAIV (nasal)						
Haemophilus Influenzae Type b (Hib)						
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13						
Hepatitis A (HepA)						
Rotavirus						
Other Vaccines: (Type and Date)						

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		<input type="checkbox"/> M <input type="checkbox"/> F		

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	29	28	27	26	25	24	23	22	21	20	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

ADMINISTRATIVE
REGULATION

Peters Township School District
Health History for School Nurse

TO HELP US GET TO KNOW YOUR CHILD BETTER AND PROVIDE NECESSARY CARE, PLEASE COMPLETE THE FOLLOWING:

Name: _____ Grade: _____ School Year: _____

Asthma
Medication: _____

Head Injury/Concussion

Allergies:
Food: _____

Hearing Defect

Medication: _____

Heart Disease

Bee/Insect: _____

Congenital Defect: _____

Other: _____

Murmur: _____

Does your child have an Epi-Pen? Yes No

Activity Restriction? Yes No

Congenital Condition
Explain: _____

Hospitalization:
Date/s: _____
Reason: _____

Diabetes

Psychological Concern

Fainting

ADHD

Headaches

PDD

Diagnosis of Migraines

ODD

Autism Spectrum

Other: _____

1. Please list any daily medication/s: _____

2. Is the student presently under care of a physician for a medical or psychological condition?

3. Does the student have any activity restrictions? _____

Parent Signature: _____ Date: _____