Required Health Forms

Student's Name ____

Student's Grade ____

- ☐ Physical Form (K, 6, Entry)
- ☐ Dental Form (K, 3, 7, Entry)
- ☐ Health History (PreK, K, Entry)
- ☐ Immunization Record (PreK, K, Entry)
- ☐ Sports Physical Form (6, 7, 8)

The Attached forms are to be completed and returned to LAMS no later than August 15th. Feel free to call the school if you have questions. Thank you.

HEALTH REQUIREMENTS

Required Immunizations:
The Pennsylvania School Immunization Law requires the following minimum immunizations for all students entering school for the first time at the kindergarten or first grade level. Before your child may attend school in Pennsylvania you must show proof that your child has had all of the following:

- Four doses of tetanus, diphtheria and acellular pertussis, with one dose administered **on or after the fourth birthday**
- Four doses of polio, with fourth dose **on or after the 4th birthday** (*a fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*)
- Two doses of measles, mumps, rubella, preferably given as an MMR, with the **first dose administered at 12 months of age or older** and the second dose administered at least 30 days after the first dose
- Three properly spaced doses of hepatitis B vaccine, with a minimum of 28 days between the first and second doses, and the third dose separated by at least 4 months after the first dose and at least two months after the second dose. The third dose must be given after 6 months (24 weeks) of age.
- Two doses of varicella (chickenpox) vaccine; OR a written statement from the parent, guardian, or health care provider noting the age of the child when he/she had the chickenpox disease.
- Children entering 7th grade need the following additional vaccines:
- One dose of tetanus, diphtheria, acellular pertussis (Tdap) vaccine; if 5 years have elapsed since the last tetanus immunization.
- One dose of meningococcal conjugate vaccine given after 10 years of age.

Proof of immunization is required before a student may enter school for the first time or transfer from another school. Proof of immunization means a **written verifiable record** showing the dates (month, day, year) your child was immunized. **The only exemptions to the school laws for immunization are for medical reasons documented by your medical doctor and for religious beliefs.** (Exemption forms are available in the LAMS office).

Required Health Forms:
- Physical Form (Grades K, 6, Entry)
- Dental Form (Grades K, 3, 7, Entry)
- Health History (All new students)
- Immunization Record (All new students)
- Sports Physical Form (Grades 6, 7, 8)

All forms need to be completed and return to LAMS no later than August 15, or upon acceptance.

LITITZ AREA MENNONITE SCHOOL
HEALTH HISTORY

____
Date

Name: ____
Last First Middle

Address: ____

Phone: _________________________ Birthdate: ____________________________

Father's Name: _______________________ Mother's Name: _________________________

Name of School: _________________________ Grade: ____________ Age: ____________

HEALTH BACKGROUND

Information relative to your child's health may be shared with appropriate school personnel when necessary to meet your child's educational, health, and safety needs.

1. Please give the dates or approximate age that your child had the following diseases:

Chicken Pox ____________________ Pneumonia __________________

Rheumatic Fever __________________ Infectious Mononucleosis __________________

Other ____

2. Has your child ever been in the hospital or had an operation? **NO** **YES**

If yes, when? __________________ Reason: ____________________________________

____

3. Has your child had any other illnesses, accidents, or broken bones? **NO** **YES**

If yes, when? __________________ What problem? ________________________________

____

4. Name of child's doctor or clinic: ____

5. Is your child receiving treatment from a doctor or clinic at present? **NO** **YES**

If yes, explain: ____

6. Is your child taking medicines? **NO** **YES**

If yes, what? __________________ Why? ______________________________________

7. Has your child ever been seen by a dentist? **NO** **YES**

Name of dentist: _________________________ Date of last visit: ______________________

8. Is your child restricted from physical activity? **NO** **YES**

If yes, explain: ____

9. Does your child need special seating in the classroom? **NO** **YES**

If yes, explain: ____

OVER

SIDE 2

10. Has your child had trouble with any of the following? (see question #12 for additional space to write information)

Ears or Hearing:	**NO**	**YES:**	If yes, explain:_______________
Eyes or Vision:	**NO**	**YES:**	If yes, explain:_______________
Convulsions or Seizures:	**NO**	**YES:**	If yes, explain:_______________
Food Intolerance:	**NO**	**YES:**	If yes, explain:_______________
Diabetes:	**NO**	**YES:**	If yes, please provide information on lines #12 and #13 below.
Stomachaches (more than usual):	**NO**	**YES:**	If yes, explain:_______________
Asthma:	**NO**	**YES:**	If yes, please provide information on lines #12 and #13 below.
Bee Sting Sensitivity:	**NO**	**YES:**	If yes, describe reaction:_______________
Allergies:	**NO**	**YES:**	If yes, describe:_______________
Colds:	**NO**	**YES:**	If yes, explain:_______________
Fevers:	**NO**	**YES:**	If yes, explain:_______________

11. Does your child have any other special health needs or problems not listed above that the school should know about?

NO **YES:** If yes, explain: _______________

____

12. Please use this space to further explain any of the items mentioned in #10 or #11 as necessary._______________

____

13. What do you want the school nurse to do about any of the above discussed problems if anything should occur in the school?_______________

____

14. **Tuberculosis (TB) Risk Assessment:** Routine skin testing for tuberculosis in children with no risk factors is not recommended; therefore, the following questions will help to determine whether your child is considered to be at increased risk for acquiring tuberculosis.

1.) Has your child had any contact with an adult with infectious tuberculosis? **NO** **YES**

2.) Were you or your child born, or did you live in a country where TB is common (e.g., Asia, Africa, Caribbean Islands, Latin America, Mexico, Middle East, Philippines, Russian Fed, or South America)? **NO** **YES**

3.) Does your child have any of the following medical risk factors: Diabetes, chronic kidney failure, chronic respiratory disease, or chronic illness associated with malnutrition? **NO** **YES**

4.) Does your child have a disease or receive treatment that affects his or her immune system, such as cancer, leukemia, lymphoma, Hodgkin's disease, or HIV infections? **NO** **YES**

5.) Does your child have frequent contact with persons in any of the following groups: Residents of nursing homes, migrant farm workers, IV drug abusers, HIV positive persons, homeless individuals, or incarcerated persons? **NO** **YES**

Person completing health history _______________ **Date** _______________
(signature)

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__________

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 NAME:

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 ☐**

STUDENT NAME:

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)
STUDENT NAME:

H514.027 (08/2011-under review)

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		☐ M ☐ F		

ADDRESS

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