Health Requirements

Health History

- Complete the front and back of the attached Health History Form, including your record of your child's immunizations.

Physical Exam

- Pennsylvania Department of Health regulations require that all children entering school for the first time have a physical examination. This examination may be completed up to twelve months prior to the beginning of school by the child's physician, at the parent's expense or may be completed during the school year by our school physician, free of cost.

Dental Exam

- Similarly, the Pennsylvania Department of Health also requires school age children to have dental examinations upon entry into school. This examination may be completed up to twelve months prior to the beginning of school by the child's family dentist, or may be completed during the school year by our school dentist. (School Dental Health Record – form attached)

Immunizations

- In addition, parents must provide written proof of their child's immunization record. This written record must include the month, day and year for each immunization and will be reviewed by the school nurse prior to the first day of school.

The immunizations and the number of required doses are listed below:

- 4 doses of tetanus* (1 dose on or after the 4th birthday)
- 4 doses of diphtheria* (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles**
- 2 doses of mumps**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) vaccine or history of disease (new regulation for 2010/2011 school year)

*Usually given as DTP or DtaP or DT or Td
**Usually given as MMR

Children will not be permitted to enter school until a record of immunizations is provided and all required immunizations are verified. Parents are advised to start checking their child's immunization records now in order to make up any deficiencies prior to the start of school.

HEALTH HISTORY

Student's Name: ____ __________

Last First Middle Date of Birth

Medications (name and dose):____

____

Does your child have any of the following?

Allergy (Type):____

____

Asthma: ________ Seizures: ________ Diabetes:________ Headaches:________

Dental Problems (explain):____

Hearing Problems (explain):____

Eye Problems (explain): ____

____Wears Glasses _____Wears Contacts

Hospitalizations / Operations(Reasons / Dates): ________________________________

____

___Anemia
___Arthritis
___Blood Pressure Problems
___Carcinoma or Tumors
___Chicken Pox (Date:__________)
___Constipation
___Diarrhea
___Eczema
___Heart Disease
___Heart Murmur
___Hepatitis (Type:_____________)
___HIV / AIDS
___Measles
___Meningitis
___Mononucleosis
___Mumps
___Pneumonia
___Polio
___Rheumatic Fever
___Scarlet Fever
___Sinus Problems
___Skin Condition (Type:_____________)
___Strep Throat
___Tuberculosis / Positive TB test
___Urinary Tract Infections
___Whooping Cough

Other Illness(specify):____

Emotional / Behavioral History (Note special problems / age of occurrence):

Anger:____________________________ Depression:____________________________

Eating Disorder:_______________________ Wetting / Soiling:_________________________

Other:____

Is your child restricted in physical activities?(explain)__________________________________

____

Learning Disabilities (explain): ____

Speech Difficulty (explain):____

__________I prefer the family physician's examination of my child

__________I prefer the school physician to examine my child

Parent Signature:____________________________________ **Date**:_____________________

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