GATEWAY SCHOOL DISTRICT

MONROEVILLE, PENNSYLVANIA

HEALTH SERVICES DEPARTMENT

Dear Parents/Guardian,

The Pennsylvania School Code currently requires examinations for new enterers (K or first), sixth and eleventh grades. Dental examinations are required for new enterers (K or first), third and seventh grades. Enterers at other grade levels (transferees) from other school districts must be examined if adequate health records are not received from previous school.

Most parents/guardians elect to have their child's exam done privately. Section 1402(f) of the Public School Code allows for accepting reports of private exams one year prior to the student's entry into the grade where an exam is required(previously it was only accepted four months prior to those grades).

Please submit the required examination report to the school nurse in your child's building by October 1. If you prefer to have your child examined in school by the school physician, or a dental screening completed in school by the school dentist, your signed consent must be sent to the school nurse before the child will be scheduled. If no report is received, the school nurse will send a reminder with a consent form included.

Note: All immunizations recorded on the physical exam report form should indicate month/day/year that the vaccine was administered.

Thank you for your attention to these school requirements.

Sincerely,

Tammy Gladkos RN, BSN, CSN

School Nurse

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 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 ☐ 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 _____

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	CHECK ONE: *ABNORMAL	CHECK ONE: 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 ☐**

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)

GATEWAY SCHOOL DISTRICT
Health History

Student's Full Name: _____ Grade: _____
Date of Birth: _____ Address: _____
_____

Gender Male _____ Female_____

Immunizations Required – Attach a Copy of Immunizations

Current Health Problems: _____

Current Medications: _____

Previous Surgeries/Hospitalizations: _____

Food Allergies? ☐ Yes ☐ No
Specify (list)_____ If yes, type of reaction and treatment required: _____

Medication Allergies? ☐ Yes ☐ No
Specify (list)_____ If yes, type of reaction and treatment required: _____

Does the student currently have or a history of:	Yes	No	If yes, please explain
Allergies - Environmental/Season (specify)	☐	☐	
Arthritis/Rheumatic Disease	☐	☐	
Asthma	☐	☐	
Attention Deficit Disorder (ADHD/ADD)	☐	☐	
Autism	☐	☐	
Bee Sting/Insect Allergies (specify)	☐	☐	
Bleeding Disorder or Cooley's Anemia	☐	☐	
Born Prematurely, Developmental, or Speech Delay	☐	☐	
Cancer	☐	☐	
Cardiovascular (Heart) Condition	☐	☐	
Cerebral Palsy	☐	☐	
Diabetes Type 1	☐	☐	
Diabetes Type 2	☐	☐	

Does the student currently have or a history of:	Yes	No	If yes, please explain
Dietary Restrictions	☐	☐	
Drug or Alcohol Issues	☐	☐	
Ear, Nose, Throat Conditions	☐	☐	
Eating Disorder	☐	☐	
Emotional or Mental Health Issues	☐	☐	
Epilepsy/Seizure Disorder	☐	☐	
Gastrointestinal (Stomach) Problems	☐	☐	
Genetic Disorder	☐	☐	
Hearing Deficit	☐	☐	
High Blood Pressure	☐	☐	
Migraines or Headaches	☐	☐	
Muscle Disorder	☐	☐	
Neurological (Concussion/Traumatic Brain Injury)	☐	☐	
Orthopedic (Bone) Disorder	☐	☐	
Physical Restrictions	☐	☐	
Scoliosis	☐	☐	
Skin Conditions	☐	☐	
Spina Bifida	☐	☐	
Tourette's Disease	☐	☐	
Urinary Problems	☐	☐	
Vision Deficit	☐	☐	
Any other conditions not listed	☐	☐	

Any medication to be administered during school hours requires a written physician order and written parent/guardian permission.

It is the responsibility of the parent/guardian to inform the school nurse of any changes in the health condition of the student.

_____ _____

Parent/Guardian Signature Date

Allegheny County Health Department

Lead Testing Record

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: _____/_____/_____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

To be filled out by health care provider

Date of most recent lead test: ____/_____/____

X _____

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, health department staff)

Date: ____/_____/____

If exemption is requested, please fill out back of form.

Other acceptable proof of testing: any written statement by the child's health care provider.

Complete only if exemption is requested

Allegheny County Health Department

Statement of Exemption to Lead Testing Regulation

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: ____/_____/____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

Religious or Strong Moral/ Ethical Conviction Exemption

State your reason/s for requesting this exemption (required): _____

_____

_____

_____

Signed _____ Date ____/_____/____

(Parent or guardian)

To be filled out by health care provider

Medical Exemption

The physical condition of the above-named child is such that blood lead testing may be detrimental to his/her health.

Signed _____ Date ____/_____/____

(Physician)

H514.027

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 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

GATEWAY SCHOOL DISTRICT

Permission to Share Health Information

The following health-related information regarding my child may be shared with appropriate school staff either verbally or in writing by the school nurse. All written material referring to this information shall be clearly labeled "**CONFIDENTIAL**" and should not be discussed with the student in the presence of other students, staff, or visitors, etc. School personnel who receive such information are to use it only to help provide a safe and healthy learning environment for the student.

I will notify the school nurse assigned to the student's building in writing, if a change occurs. All information may be made available to the staff as indicated each year until and unless I request a change.

I understand that certain health related information may require written and signed physician or licensed health care provider instructions to the school nurse. If this information is requested I shall comply.

LIST HEALTH INFORMATION HERE:

_____ _____

Signature of Parent/Guardian Date