# 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, Jamy Galles RN, BSN, CSN

School Nurse

# ANAVIRO SE POR ESTADOS ESTADOS

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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 <u>before</u> student's exam. Take completed form to appointment.

Date of birth	birth Age at time of exam						
Medicines and Allergies: Please list all prescription and over	er-the-c	ounter m	edicines and supplements (herbal/nutritional) the student is currently	taking	g:		
Describe student hour any allowing 2 CAL CAV (II	P. 4		J. J. Daniera	1	7		
Does the student have any allergies? ☐ No ☐ Yes (If yes,	list spec	cific allerg	gy and reaction.)				
☐ Medicines ☐ Pollens			□ Food □ Stinging Insects				
Complete the following section with a check mark in th	e YES	or NO co	olumn; circle questions you do not know the answer to.				
GENERAL HEALTH: Has the student	YES	NO	GENITOURINARY: Has the student	YES	s l		
Any ongoing medical conditions? If so, please identify:			<ul><li>29. Had groin pain or a painful bulge or hernia in the groin area?</li><li>30. Had a history of urinary tract infections or bedwetting?</li></ul>				
2. Ever stayed more than one night in the hospital?	-	-		Yes			
3. Ever had surgery?  4. Ever had a seizure?			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:				
5. Had a history of being born without or is missing a kidney, an eye, a			DENTAL:	I .v.= 6	Toron La		
testicle (males), spleen, or any other organ?			32. Has the student had any pain or problems with his/her gums or teeth?	YES			
6. Ever become ill while exercising in the heat?			33. Name of student's dentist:	100			
7. Had frequent muscle cramps when exercising?	nii unununununu	1920 1990 1991	Last dental visit:  less than 1 year  1-2 years  greater than	2 4000			
HEAD/NECK/SPINE: Has the student	YES	NO	SOCIAL/LEARNING: Has the student	Liningson	and I		
. Had headaches with exercise?	_		34. Been told he/she has a learning disability, intellectual or	YES			
Ever had a head injury or concussion?			developmental disability, cognitive delay, ADD/ADHD, etc.?		- 1		
2. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			35. Been bullied or experienced bullying behavior?	-			
I. Ever had numbness, tingling, or weakness in his/her arms or legs	-	-	36. Experienced major grief, trauma, or other significant life event?		٦		
after being hit or falling?			37. Exhibited significant changes in behavior, social relationships,		7		
2 Ever been unable to move arms or legs after being hit or falling?			grades, eating or sleeping habits; withdrawn from family or friends?		4		
Noticed or been told he/she has a curved spine or scoliosis?			38. Been worried, sad, upset, or angry much of the time?  39. Shown a general loss of energy, motivation, interest or enthusiasm?	17 11 147	+		
Had any problem with his/her eyes (vision) or had a history of an eye injury?			40. Had concerns about weight; been trying to gain or lose weight or		+		
is Been prescribed glasses or contact lenses?			received a recommendation to gain or lose weight?				
EART/LUNGS: Has the student	YES	NO	41. Used (or currently uses) tobacco, alcohol, or drugs?	magh	1		
Ever used an inhaler or taken asthma medicine?			FAMILY HEALTH:	YES			
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  □ High cholesterol  □ Other:  □ Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?			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				
Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		-	43. Is there a family history of any of the following heart-related problems? If so, check all that apply:		t		
Had discomfort, pain, tightness or chest pressure during exercise?			☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome				
Felt his/her heart race or skip beats during exercise?			☐ High blood pressure ☐ Ventricular tachycardia				
DNE/JOINT: Has the student	YES	NO	☐ High cholesterol ☐ Other				
Had a broken or fractured bone, stress fracture, or dislocated joint?  Had an injury to a muscle, ligament, or tendon?			44. Has any family member had unexplained fainting, unexplained		+		
Had an injury that required a brace, cast, crutches, or orthotics?			seizures, or experienced a near drowning?	-	1		
Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?			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				
Had joints that become painful, swollen, feel warm, or look red?			death syndrome)?  QUESTIONS or CONCERNS				
IN: Has the student	YES	NO	46. Are there any questions or concerns that the student, parent or	YES			
Had any rashes, pressure sores, or other skin problems?  Ever had herpes or a MRSA skin infection?			guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)	950			
in information between the school nurse and heal	the in	formation	on is true and complete. I give my consent for an exchange	ge of			
nature of parent / guardian / emancipated student			Date		ege		

Pulse: ( )	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFER  *ABNORMAL FINDINGS / RECOMMENDATIONS / RECOMME		AND DEPARTMENT	СН	IECK C	NE	
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Physical exam performed at: Personal Health Care Provider's Office 🗌 School 🗆 Date of exam20	Print examiner's office address Phone						Phone Phone

### HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record – OR – insert information below.

IMMUNIZATION EXEMPTION(S):						
Medical Date Issued:	Reason:			Date Res	cinded:	
Medical Date Issued:		Date Rescinded:				
Medical Date Issued:	Date Res	cinded:				
NOTE: The parent/guardian must provid	le a written requ	est to the school for	a religious or philos	cophical exemption.		
VACCINE	DOCU	MENT: (1) Type of	vaccine; (2) Date (	month/day/year) fo	or each immunization	
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	_	2	3	4	5	
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5	
Polio Type: OPV or IPV		2	3	4	5	
Hepatitis B (HepB)		2	3	4	5	
Measles/Mumps/Rubella (MMR)	1	2	3	4	5	
Mumps disease diagnosed by physician	Date:					
Varicella: Vaccine Disease		2	3	4	5	
Serology: (Identify Antigen/Date/POS or NEC i.e. Hep B, Measles, Rubella, Varicella	S) 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	6	7	8	9	10	
Type: TIV (injected) LAIV (nasal)	-			-11		
	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	
	Oth	ner Vaccines: (Typ	e and Date)			
			- 1 - 1			

Page 4 of 4: ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)	
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## GATEWAY SCHOOL DISTRICT Health History

Date of Birth: Address:			Grade:
Gender Male Female			anditano agari Legari
***Immunizations Required – Attach	a Copy	of Im	munizations***
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Current Medications:			
Current Medications:			
Previous Surgeries/Hospitalizations: Food Allergies?		If	yes, type of reaction and
Medication Allergies?  Yes No Specify (list) treatment required:		If y	es, type of reaction and
Does the student currently have or a history of:	Yes	No	If yes, please explain
Allergies - Environmental/Season (specify)			structi (Anad) suppre
Arthritis/Rheumatic Disease			aroti, lung di Viring
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ttention Deficit Disorder (ADHD/ADD)			ii Ondiodus
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ee Sting/Insect Allergies (specify)			pendd sylm o
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ardiovascular (Heart) Condition			
erebral Palsy			May be of transmitted to the Little of the L
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abetes Type 2			obstage in the beside con

Does the student currently have or a history of:	Yes	No	If yes, please explain
Dietary Restrictions			o principal de Charles
Drug or Alcohol Issues	dele		: mrill to-enigh
Ear, Nose, Throat Conditions			pro-1 state isotos.
Eating Disorder			
Emotional or Mental Health Issues			
Epilepsy/Seizure Disorder			m-king atash mana
Gastrointestinal (Stomach) Problems			
Genetic Disorder			
Hearing Deficit			(bil) Mosk
High Blood Pressure			
Migraines or Headaches			Piyde agon Anuqios, , , re
Muscle Disorder			
Neurological (Concussion/Traumatic Brain Injury)			
Orthopedic (Bone) Disorder			
Physical Restrictions			
Scoliosis			
Skin Conditions			lactific references to metall contribut
Spina Bifida			
Tourette's Disease			
Urinary Problems			
Vision Deficit			
Any other conditions not listed			7637



## 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:	- Company desires de la company de la compan		
To be filled out b	by health care provider		
Date of most recent lead test://			
X			
<b>Signature</b> (PLEASE CIRCLE - physician, assistant, health department staff)	certified registered nurse	practitioner,	physician
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.

# 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)

# COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH

# PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

	OF SCHOOL												ATE _					20
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#### 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