# Saint Mary Catholic School

Dear Parents/Guardians,

Welcome to St. Mary's! I would like to introduce myself as a certified school nurse of the Perkiomen Valley School District and the primary nurse at St. Mary's Catholic School on Fridays. I look forward to working with you at St. Mary's to insure the health and wellness of your child.

Pennsylvania School Health Law requires a medical examination and a dental examination for all new entrants to school. It is recommended that your family doctor complete these examinations. These examinations must be completed after July 1, 2018.

**Registration will be considered incomplete without immunizations. Immunizations should be submitted at the time of registration and updates forwarded to the school nurse as soon as possible. Your child risks exclusion from school if the medically appropriate vaccines have not been received prior to the first day of school.**

Pennsylvania's mandated screening program consists of height/weight/BMI (body mass index) and vision screening for all students, K to 12. Students in grades K-3, 7th and 11th will also receive a hearing test. Scoliosis screenings will be completed on 7th grade students. This will be completed in the fall of each school year by the school nurses of Perkiomen Valley School District.

The following are important reminders of when students should remain at home due to illness:

1. Your child should be fever free for 24 hours without any medication before returning to school.

2. Children with vomiting and diarrhea are to be kept home for 24 hours after the last episode.

3. Children with suspected infectious diseases (i.e. pink eye and any unknown rashes) should be kept home until verification from your health care provider/ medical clearance can be obtained.

4. All medication, including over the counter medications such as Tylenol, need a Doctor's note and must be in the original container. No loose medication will be dispensed to students. Students are not permitted to carry medication with them. It must be brought to the office at the beginning of the school day.

5. If your child is sick, they should be kept home regardless of parties, field trips or other special events. Children may want to come to school but they are usually too sick to be here and risk infecting their classmates and staff.

Please don't hesitate to contact me or the St. Mary School office with any concerns @ 610-287-7757.

Sincerely,

Amy Torrence BSN, RN, CEN
Certified School Nurse
nurse@smsk-8.org

# Perkiomen Valley School District School Health Services

## Requirements for Student Registration

Please return completed packet to St. Mary's School, Attn: school nurse or scan to nurse@smsk-8.org.

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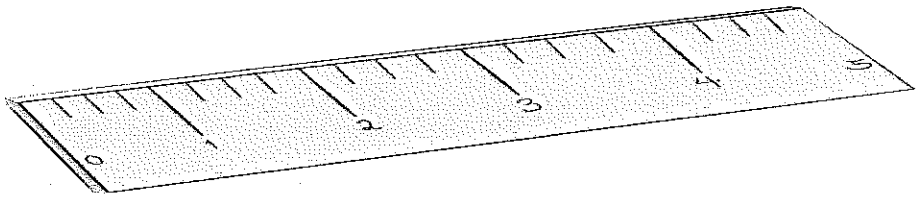
- Complete Immunization Record
  - PA Law mandates that every child K-12 be immunized on the 1st day of school.
  - For more information on the vaccines your child needs in order to attend school, talk to your healthcare provider, school nurse, or visit www.montcopa.org/schoolvaccinelaw
- Health Emergency Form
- Tuberculosis Screening Form
- Physical Examination Form (dated July 1,2018 forward)
  - Pennsylvania School Health Law requires a medical examination for children on initial entry to school (i.e., Kindergarten or First grade), 6th grade, and 11th grade
- Dental Examination Form (dated July 1, 2018 forward)
  - Pennsylvania School Health Law requires a dental examination for children on initial entry to school (i.e., Kindergarten or First grade), 3rd grade, and 7th grade

Please contact the School Nurse with questions or concerns regarding these requirements Nurse@smsk-8.org.

Thank you,
Amy Torrence M.ED, RN
Certified School Nurse

# IMMUNIZE!

## *"It's the Rule for Back to School."*



## *PA Law mandates that every child K-12 be immunized on the 1st day of school.*

**Vaccination Requirements**

| Vaccines | Kindergarten & Grades 1-6 | Grades 7-11 | Grade 12 |
|---|---|---|---|
| **Tetanus, diphtheria, and acellular pertussis** (Usually given as DTaP, DTP, DT, or Td) (1 dose on or after 4th birthday) | **4 doses** | **4 doses** | **4 doses** |
| **Polio** (4th dose on or after 4th birthday and at least 6 months after previous dose given) | **4 doses** (A 4th dose is not necessary if the 3rd dose was administered at age 4 years or older and at least 6 months after the previous dose) | **4 doses** (A 4th dose is not necessary if the 3rd dose was administered at age 4 years or older and at least 6 months after the previous dose) | **4 doses** (A 4th dose is not necessary if the 3rd dose was administered at age 4 years or older and at least 6 months after the previous dose) |
| **Measles, Mumps, & Rubella** (Usually given as MMR) | **2 doses** | **2 doses** | **2 doses** |
| **Hepatitis B** | **3 doses** | **3 doses** | **3 doses** |
| **Varicella (chickenpox)** | **2 doses** or evidence of immunity | **2 doses** or evidence of immunity | **2 doses** or evidence of immunity |
| **Tetanus, diphtheria, acellular pertussis (Tdap)** | **Not applicable** | **1 dose** | **1 dose** |
| **Meningococcal Conjugate (MenACWY)** | **Not applicable** | **1 dose** (First dose is given at 11-15 years of age; a second dose is required at age 16 or entry into 12th grade) | **1 or 2 doses** (If 1st dose of MenACWY was given at 16 years of age or older, that shall count as the 12th grade dose) |

**For more information on the vaccines your child needs in order to attend school, talk to your healthcare provider, school nurse, or visit www.montcopa.org/schoolvaccinelaw**

MCHD
montgomery county health department
OF PENNSYLVANIA

# Perkiomen Valley School District
# HEALTH EMERGENCY INFORMATION

NAME: _____ _____ _____
*Last First Grade Home Room Teacher*

ADDRESS: _____ ☐ Male ☐ Female ____/____/_____
*Street Date of Birth*

_____ _____ (____)_____
*City, State, Zip Code Bus # Primary Phone Number*

LIVES WITH: ☐ Both Parents ☐ Shared Custody* ☐ Mom ☐ Dad ☐ Other: _____

*Court Order/Custody Papers on file: ☐ YES ☐ NO

Student should **NOT** be released to: _____

MOTHER/GUARDIAN _____ Employer: _____
*Last, First*

CELL #_____ WORK # _____ EMAIL: _____

FATHER/GUARDIAN _____ Employer: _____
*Last, First*

CELL #_____ WORK # _____ EMAIL: _____

List 2 LOCAL relatives/friends who will assume temporary care of your child if necessary:

_____ _____ (____)_____
*Name Relationship to Student Phone Number*

_____ _____ (____)_____
*Name Relationship to Student Phone Number*

List other siblings in the district:

_____ _____ _____
*Name Grade School*

_____ _____ _____
*Name Grade School*

MEDICAL INFORMATION: Please check all that apply (provide explanation on back or additional sheet if needed)

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ Bleeding Disorder | ☐ Cancer | ☐ Wears Glasses |
| ☐ Emotional Problems | ☐ Hearing Loss | ☐ Seizures | ☐ Wears Contacts |
| ☐ Heart Condition | ☐ Long QT Syndrome | ☐ Cystic Fibrosis | ☐ History of Fainting Spells |
| ☐ Orthopedic Problems | ☐ Vision Problems | ☐ Diabetes | ☐ Family history of sudden death (unknown cause) |
| ☐ ADD/ADHD | | | |

Insect Allergy to : _____ Epi-Pen Needed: ☐ YES ☐ NO
Seasonal Allergy to : _____ Epi-Pen Needed: ☐ YES ☐ NO
Food Allergy to : _____ Epi-Pen Needed: ☐ YES ☐ NO
Medical Allergy to : _____ Epi-Pen Needed: ☐ YES ☐ NO

Long term medications that your child is taking: _____

Other health concerns: _____

This medical information may be shared with school staff: ☐ YES ☐ NO

***In case of emergency, when parents or emergency numbers cannot be reached, I give permission to school authorities to use their judgement in obtaining care for this student.***

***Parent/Guardian Signature*** _____ ***Date*** _____

Perkiomen Valley School District

3 Iron Bridge Drive • Collegeville, PA 19426

STUDENT NAME: _____ DATE OF BIRTH: _____

PART A: Tuberculosis Exposure Risk Assessment Questionnaire for Students:

1. Was the student born outside the United States?
   Yes:
   - What country: _____
   - Is this country listed as having an incidence rate ≥ 20 per 100,000 cases as per the World Health Organization (WHO) document? *YES/NO
   - * If YES, then testing is required within 30 days of admission to school, AND
   - Perform TB Symptom Screening (Part B)

2. Has the student traveled outside the United States for ≥ 90 days?
   Yes:
   - What country? _____
   - Is this country listed as having an incidence rate ≥ 20 per 100,000 cases as per the World Health Organization (WHO) document? **YES/NO
   - ** If YES, then testing (performed in the U.S.) is required within 8-10 weeks of return to the U.S., AND
   - Perform TB Symptom Screening (Part B)

PART B: Tuberculosis Symptom Screening for Students:

If the student is identified as having a risk of TB exposure (as listed in questions 1 and 2): does the student now have symptoms of TB disease?

- Cough greater than 3 weeks ____ yes ____ no
- Blood in sputum ____ yes ____ no
- Night sweats or fever ____ yes ____ no
- Unexplained weight loss ____ yes ____ no
- Loss of appetite ____ yes ____ no

If YES to any of the symptoms please contact Meg Lewis, Health Services Department Chair @ 610-409-6060 or mlewis@pvsd.org for medical clearance prior to admission to class.

Please feel free to call the Montgomery County Health Department TB Control program with any questions regarding screening or testing requirements:

Willow Grove office: 215-784-5415
Norristown office: 610-278-5145
Pottstown office: 610-970-5040

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:<br>☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection<br>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:<br>☐ Heart murmur or heart infection<br>☐ High blood pressure ☐ Kawasaki disease<br>☐ 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<br>If yes: At what age was her first menstrual period? _____<br>How many periods has she had in the last 12 months? _____<br>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: _____<br>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:<br>☐ Anemia/blood disorders ☐ Inherited disease/syndrome<br>☐ Asthma/lung problems ☐ Kidney problems<br>☐ Behavioral health issue ☐ Seizure disorder<br>☐ Diabetes ☐ Sickle cell trait or disease<br>Other_____ | | |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply:<br>☐ Brugada syndrome ☐ QT syndrome<br>☐ Cardiomyopathy ☐ Marfan syndrome<br>☐ High blood pressure ☐ Ventricular tachycardia<br>☐ 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 _____

**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)<br>Type: DTaP, DTP or DT | 1 | 2 | 3 | 4 | 5 |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)<br>Type: Tdap or Td | 1 | 2 | 3 | 4 | 5 |
| Polio<br>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)<br>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)<br>Type: HPV2 or HPV4 | 1 | 2 | 3 | 4 | 5 |
| Influenza<br>Type: TIV (injected)<br>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)<br>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

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