THE SCHOOL DISTRICT OF
PHILADELPHIA
School Health Services

To the Parent/Guardian of: _____ DOB: _____ Grade: _____
School: _____ Date of Notification: _____

The School District of Philadelphia and Pennsylvania Department of Health require all students attending school to be immunized.
The above student is conditionally enrolled in the School District of Philadelphia according to PA Department of Health requirements.
The parent / guardian of the student has 5 business days from the first day of school or enrollment to provide the information listed below to avoid exclusion from school.
____ Proof of the immunization record provided to the School Nurse by _____, 20___.

OR

____ Proof of an appointment provided to the School Nurse in the form of an appointment card or letter signed by the Health Care Provider. This must be provided to the School Nurse by _____, 20___.
Failure to be fully immunized or one missed appointment will result in exclusion from school until the vaccine is given and verification provided.
Call your child's doctor to schedule an appointment. If you do not have a doctor or cannot get an appointment, you may set up an appointment by calling:

City District Health Centers – 215-685-2933

Please see below for the specific vaccines your child is missing and take this sheet with you to your child's physician appointment

Regulations are as follows for all students in grades K-12: *Your child needs:*

- 4 doses of Tetanus, Diptheria and Acellular Pertussis (DPT) _____Doses of Dtap
  (1 dose on or after the 4th birthday unless 3rd dose after age 4 or is 6 months after 2nd dose)
- 4 doses of Polio _____doses of Polio
  (4th dose on or after 4th birthday & 6 months after 3rd dose)
- 2 doses of Measles, Mumps, Rubella _____doses of MMR
- 3 doses of Hepatitis B _____doses of Hep B
- 2 doses of Varicella (chickenpox vaccine) _____doses of varicella
  (or documentation of immunity/having disease from a parent, physician, CRNP, PA or laboratory)

Students entering 7th grade and in grades 8-12th need the following additional vaccines:

- 1 dose of Tetanus, Diptheria and Acellular Pertussis (TDAP) _____dose of Tdap
- 1 dose of Meningococcal Conjugate Vaccine (MCV) _____dose of MCV

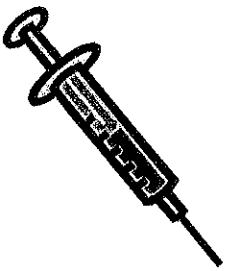
Students entering grade 12 or at the age of 18 years, need the following vaccines:

- A second dose of Meningococcal Conjugate Vaccine (MCV) _____dose of MCV
  *If first dose was given at age of 16 years or older this dose is not needed.

We cannot overstate the importance of making sure our students are attending school every day, on time, and are healthy and ready to learn. If you have any questions please visit http://kids.phila.gov/index.php/new-school-immunizations-requirements-frequently-asked-questions. Or call your school nurse.

_____ _____
School Nurse Phone Number

SCHOOL DISTRICT OF PHILADELPHIA



IMMUNIZATION ALERT

Dear Parent/Guardian of _____
STUDENT NAME

A Health Services review of your child's Immunization Record indicates that, our child has not received all of his/her **mandated** immunizations.

If your child has received all of his/her immunizations, the nurses do not have the supporting documentation on file.

Please take note; your child cannot attend school if they are not completely immunized. Proof of immunizations must be presented to the nursing office by _____.

Documentation must include the date the vaccine was given, clinic/physician name.

Your child is **missing** the following immunizations:

___All Immunizations
___DTP (4th dose must be given after 4th birthday)
___Pertusis

Polio (4 doses)
___#1
___#2
___#3
___#4

MMR
___#1
___#2

Hepatitis B
___#1
___#2
___#3

Varivax (Chicken Pox Vaccine)
___must be given after 1st birthday
___Medical documentation of active disease
___2nd Varivax

Meningococcal
___#1

Sincerely,
Barbara Ward, RN, School Nurse

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Date Issued: [Date]	Student ID#:

Name of Student:	Date of Birth:	Grade:
Name of School:	Room/Section/Book	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature_____Date_____

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

(Please attach complete immunization record including serology results if available)

- Allergies_____
- Date of last PPD_____Result_____mm

Does this student have health insurance? _____ Yes _____ No Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____
2. Audiometric Screening: R_____ L_____ 3. BP_____
4. Height_____ inches/cm Weight_____lb./kg BMI percentile_____
5. Scoliosis Screening: _____ Normal _____Abnormal _____ Referred _____ No Referral
6. Activity Recommendation: _____ Full Physical Activity _____Restricted Physical Activity
   (Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions:_____
7. List all medications currently being taken:
   Medications:_____Reason:_____
8. List ALL problems by history or examination: Circle status of problem
   1._____ Under Care Care Complete Referred
   2._____ Under Care Care Complete Referred
   3._____ Under Care Care Complete Referred
   _____ No Problems Identified

Comments/follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

THE SCHOOL DISTRICT OF
PHILADELPHIA

Student Emergency /Medical Information

Last Name:_____First Name:_____DOB: _____

School:_____Room/Sec:_____Grade:_____

Home Address: _____ Home phone: _____

Mother: _____email: _____phone: _____

Father: _____email: _____phone: _____

Guardian: _____email: _____phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child **Phone**

1._____

2._____

Childs Doctor/Clinic: _____Phone:_____

Medical Insurance: MA___ CHIP___ Private_____

Insurance company name: _____ Policy Number_____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	**YES**	**NO**
Ibuprofen (Advil, Motrin)	**YES**	**NO**

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _____

_____

Other Health Problems: _____

_____

_____

Does your child take medication? ____NO ____YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities. I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature _____**Date**_____

Revised S-865 (06/2018)

THE SCHOOL DISTRICT OF PHILADELPHIA

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments / Follow-up Treatment / Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

_____
Certified School Nurse/Practitioner

_____
School

_____
School Address

_____
Phone Number