Department of
Public Health
CITY OF PHILADELPHIA
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CITY OF PHILADELPHIA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF DISEASE CONTROL
IMMUNIZATION PROGRAM

Summary: Philadelphia Immunization Requirements For School Entry, 2015-2016

Grades	Vaccines	Requirements
K – 1	Diphtheria & Tetanus.....	4 Doses: at least one on/after 4th birthday (DTaP/DTP/DT/Td)
	Pertussis.....	4 Doses: at least one on/after 4th birthday (DTaP or DTP)
	Polio.....	3 Doses: (OPV/IPV)
	Measles.....	2 Doses: on/after 1st birthday (MMR or MMRV)
	Mumps.....	2 Doses: on/after 1st birthday (MMR or MMRV)
	Rubella.....	2 Doses: on/after 1st birthday (MMR or MMRV)
	Hepatitis B.....	3 Doses: (HBV)
	Varicella.....	2 Doses: on/after 1st birthday (Varicella or MMRV) *or* documentation of chickenpox immunity proven by laboratory testing *or* a written statement of prior chickenpox disease from a healthcare provider
2-5 and 8-12	Diphtheria & Tetanus.....	4 Doses: at least one on/after 4th birthday (DTaP/DTP/DT/Td/Tdap)**
	Polio.....	3 Doses: (OPV/IPV)
	Measles.....	2 Doses: on/after 1st birthday (MMR or MMRV)
	Mumps.....	2 Doses: on/after 1st birthday (MMR or MMRV)
	Rubella.....	1 Dose: on/after 1st birthday (MMR or MMRV)
	Hepatitis B.....	3 Doses: (HBV)
	Varicella.....	2 Doses: on/after 1st birthday (Varicella or MMRV) *
6-7	Diphtheria & Tetanus.....	4 Doses: at least one on/after 7th birthday (DTaP/DTP/DT/Td/Tdap)**
	Pertussis.....	1 Dose: at least one on/after 7th birthday (Tdap)
	Polio.....	3 Doses: (OPV/IPV)
	Measles.....	2 Doses: on/after 1st birthday (MMR or MMRV)
	Mumps.....	2 Doses: on/after 1st birthday (MMR or MMRV)
	Rubella.....	1 Dose: on/after 1st birthday (MMR or MMRV)
	Hepatitis B.....	3 Doses: (HBV)
	Varicella.....	2 Doses: on/after 1st birthday (Varicella or MMRV) *
	Meningococcal.....	1 Dose: on/after 2nd birthday (MCV4)

References: Requirements from The Pennsylvania Code – Subchapter C. *IMMUNIZATION* §23.81, amended May 28, 2010, effective August 1, 2011, and from the Philadelphia Board of Health *Regulations Governing the Health of Newborns, Children and Adolescents*, published 2009.

* Or documentation of a history of chickenpox immunity proven by laboratory testing or a written statement of history of chickenpox disease from a parent, guardian or physician.

** Only 3 doses of Td-containing vaccine are necessary if series is started on/after 7th birthday, if at least one dose is given as Tdap.

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

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT	ADDRESS/ZIP	ROOM/BOOK NO.
DATE OF BIRTH	SCHOOL	PID

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDICATION:	DOSE:
TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:
DATE BEGIN:	DATE END:

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS:

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN:

RESTRICTION ON ACTIVITY: YES ☐ NO ☐

IF YES, DESCRIBE:

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS:

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE
ADDRESS	EMERGENCY NUMBER
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

I authorize licensed school personnel to administer the indicated medication as prescribed by my child's health care provider, whose signature appears on this form

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply, as needed regarding this medication and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

In accordance with school district procedure:

- I have assessed the student and s/he has demonstrated competency to self-administer medications.
  YES___ NO_____
- The administration of this medication was approved on:

_____

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____