Health Requirements for Students Entering 6th Grade in September for the 2020-2021 School Year

Dear Parent or Guardian,

Please mail, fax, or bring a copy of the following records to the school, addressed to the attention of the school nurse.

Vaccinations are mandatory for all students!

Pennsylvania State law requires every student be fully immunized *by the first day of school* and a complete vaccination record must be on file with the school. If your child is in the process completing their vaccinations you must provide a medical certificate with the dates shots will be given. Please check with your child's doctor if you are not sure. ***If this is not done your child may not be allowed to attend school!***

A physical exam is required for 6rd grade.

Please have your child's doctor complete the enclosed *Report of Physical Examination (MEH-155).* The exam must be completed after March 1, 2020.

NO medications in school without a MED-1!

This includes Inhalers, antibiotics, and over the counter medications. A ***Request for Administration of Medication (MED-1)*** must be completed and signed by both you and your doctor. Please read the included "Medications in School" for more information.

The ***Student Medical History (S-865)*** must be completed and signed to give your permission for the School Nurse to administer Tylenol, Advil, or cortisone cream. ***This must be done every school year.*** It also helps us better understand any special health needs your child may have.

Thank you for helping to create a healthy school environment for all our children!

Sincerely,

MIchael Corbit, CSN
School Nurse

Attachments:

1. School Immunization Requirements, K-12
2. Medications in Schools
3. Report of Physical Examination (MEH-155)
4. Student Medical Information (S-865)
5. Request for Administration of Medication (MED-1)

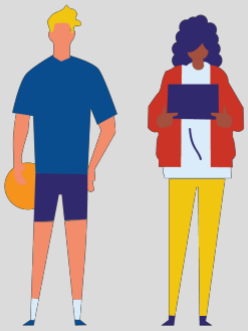
School Immunization Requirements
SCHOOL DISTRICT OF PHILADELPHIA

All Grades (K-12)

Before attending any Philadelphia schools, students from all grade levels must have received the following vaccines...*

Diphtheria, Tetanus, & Acellular Pertussis (DTap)	4 doses
Polio (IPV)	4 doses
Measles, Mumps, and Rubella (MMR)	2 doses
Hepatitis B (Hep B)	3 doses
Chickenpox (Varicella)	2 doses

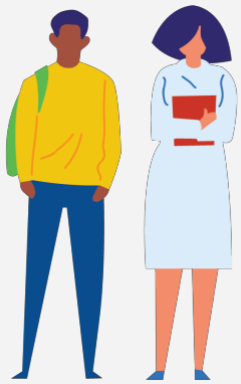
7th Grade



***In addition to the above vaccines**, before entering the 7th grade Philadelphia students must receive these additional vaccines*...*

Tetanus, Diphtheria, & Acellular Pertussis (Tdap)	1 dose
Meningococcal Conjugate (MCV4)	1 dose

12th Grade



***In addition to the above vaccines**, before entering the 12th grade Philadelphia students must receive this additional vaccine*...*

Meningococcal Conjugate (MCV4)	2 doses

*all doses must be given at the appropriate age & interval, talk to your doctor for more information

Don't have a doctor?

VISIT A CITY HEALTH CENTER

Need vaccines for your child but you don't have a doctor? Visit a Philadelphia city health center! City health centers can give your child the vaccines they need to stay healthy and enter school.

Operated by the Department of Public Health, city health centers accept patients with no insurance, Medicaid, HMO plans, and most other insurance options. Walk-in to any of the centers listed below for more information, or call (215) 685-2933 to schedule a vaccine appointment.

Need proof of a vaccine that was already given? Call the Immunization Hotline at (215) 685-6784, 9:00 am to 5:00 pm, Monday through Friday

Philadelphia City Health Centers

Health Center 2
1700 S. Broad St., Unit 201, Philadelphia, PA 19145 *(215) 685-1803*

Health Center 3
555 S. 43rd St., Philadelphia, PA 19104 *(215) 685-7504*

Health Center 4
4400 Haverford Ave., Philadelphia, PA 19104 *(215) 685-7601*

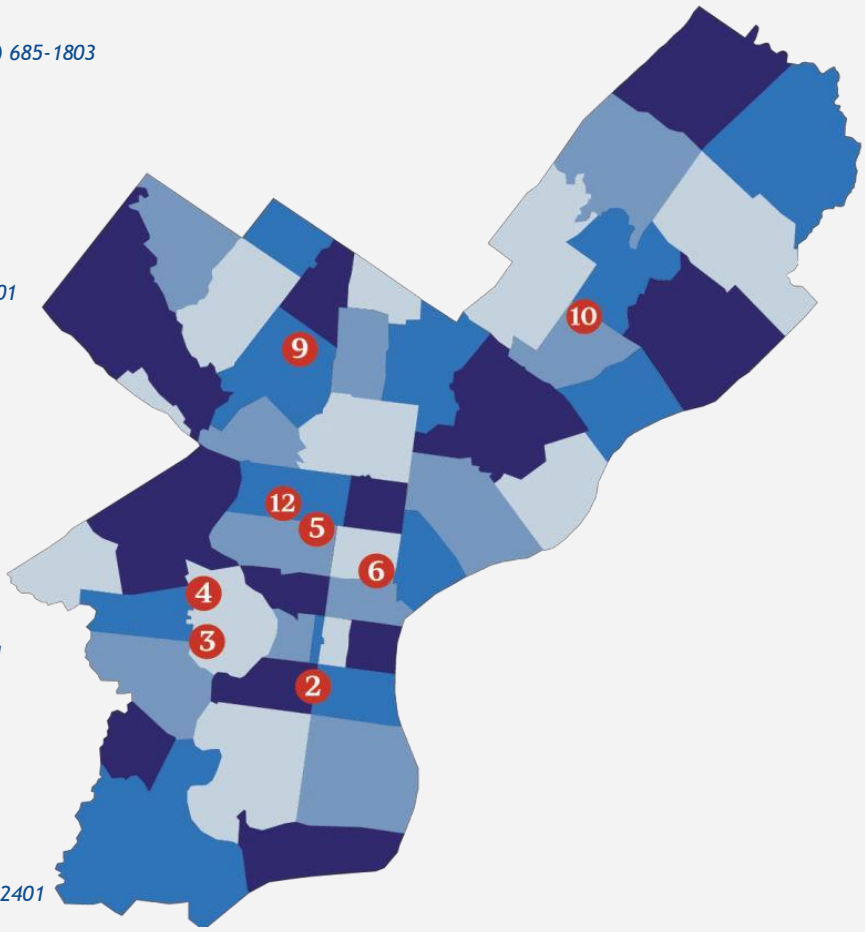
Health Center 5
1900 N 20th St., Philadelphia, PA 19121 *(215) 685-2933*

Health Center 6
301 W. Girard Ave., Philadelphia, PA 19123 *(215) 685-3803*

Health Center 9
131 E. Chelten Ave., Philadelphia, PA 19144 *(215) 685-5701*

Health Center 10
2230 Cottman Ave., Philadelphia, PA 19149 *(215) 685-0639*

Health Center 12 (Strawberry Mansion)
2840 West Dauphin St., Philadelphia, PA 19132 *(215) 685-2401*



THE SCHOOL DISTRICT OF PHILADELPHIA

Department of Public Health CITY OF PHILADELPHIA

Medication in the School

Dear parents and guardians,

Our goal is to provide the best possible care to your child while in school. To do this safely and legally we must fully adhere to Pennsylvania laws and regulations.

By state law medication may only be administered by a school nurse or other licensed health professional. In general this means medication may only be given by the School Nurse on the days they are present in the school.

The only exception to this are epinephrine auto-injectors (EpiPens) for severe allergic reaction and rescue asthma inhalers.

For every medication in school the following guidelines must be followed; for more information please refer to the student handbook.

Doctor's Order and Parental Permission are Required

- A separate "Request for Administration of Medication In School" **(MED-1)** is required for each medication in school.
- Each **MED-1** must be signed and dated by both the doctor and parent.
- Antibiotics, medications from the emergency room, and over the counter medications, may not be given without an **MED-1**
- The above must be completed even if the student self- carries and self-administers an EpiPen or asthma rescue inhaler
- The only medications students may self-carry are an EpiPen or asthma inhaler. This must be approved by the doctor, parent, and school nurse.
- The School Nurse may give Tylenol, Advil, or hydrocortisone cream only if a signed and dated "Student Emergency/Medical Information" **(S-865)** is on file in their health record. ***This must be done every school year.***

Medication Packaging

- All medication must be in the original package or container with the pharmacy label
- Medication must not be expired

End of School Year

- All medication must be picked up on the student's last day of school.
- Medication not picked up will be discarded

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School St. Barnabas School	Room/Section/Book	Date Issued	

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_____

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. Ed. Medical Exemption/Program Modification Form MEH-23)
Specify Restrictions: _____

7. List all medications currently being taken:
Medication: _____ 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:_St. Barnabas 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 (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 (06/2019)

THE SCHOOL DISTRICT OF PHILADELPHIA

OPTIONAL

Non-Aerosol Topical Sunscreen Use at School

Parents/guardians may choose to supply their child with **non-aerosol topical sunscreen**, if it is approved by the U.S. Food and Drug Administration. In order for a student to apply sunscreen during school hours, at a school-sponsored activity, or while under the supervision of school personnel, the parent/guardian must complete the attestations below.

Parent/Guardian Attestation

- By signing below, you confirm that you understand that the school is not responsible for ensuring that the sunscreen is applied by the student.
- By signing below, you confirm that the student has demonstrated that they are able to self-apply the sunscreen.

Parent/Guardian Signature:_____ Date: _____

The school may cancel or restrict the possession, application, or use of a non-aerosol topical sunscreen product by a student if any of the following occurs:

- The student fails to comply with school rules concerning the possession, application, or use of the non-aerosol topical sunscreen product.
- The student shows an unwillingness or inability to safeguard the non-aerosol topical sunscreen product from access by other students.

If a school cancels or restricts the possession, application, or use of a non-aerosol topical sunscreen product by a student, the school shall provide written notice of the cancelation or restriction to the student's parent/guardian.

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF EQUIPMENT IN SCHOOL

(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/ORG.#	REGIONAL OFFICE	PID
	St.Barnabas School		

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDICATION/EQUIPMENT/TREATMENT:	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:

IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES ☐ NO ☐

IF YES, DESCRIBE:

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS:

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES ☐ NO ☐

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

To The Principal

- I authorize the certified school nurse to administer the indicated medication, or to use the equipment or machinery 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/ equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE

- I have assessed this student and he/she has demonstrated competency and may self administer this medication/treatment (__) yes (__) no
- The administration of this medication/treatment was approved on: _____ DATE

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

MED-1 (Rev. 1/2020)

DISTRIBUTION OF COPIES: SCHOOL NURSE- KEEPS ORIGINIAL; PARENT- KEEP COPY

TO THE PHYSICIAN:
Your patient has requested that medication be administered in school. Ideally, the administration of medication should take place at home. However, for students who require medication during the school day in order to function in the classroom, School District Policy does permit licensed school staff to administer medication. In some cases, students may self-administer their medication.

IF YOUR PATIENT'S MEDICATION CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE REVERSE SIDE. A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT.

Please 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.

Thank you.

School Health Services

DEAR PARENT/GUARDIAN:

Some children need the administration of medication in order to function in the classroom. Ideally, this should take place at home. If your child's medication schedule cannot be altered and administered at home, you can request the medication to be given in school by seeing the school nurse.

Once the School Nurse has approved the request, you will be required to bring the medication to school properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T-Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

This procedure must be repeated each school year and/or each time there is a change in dosage.

Parents/guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days, or by the last day of school, will be destroyed/discarded.

If you have any questions on this procedure, please contact the school nurse.

. Thank you.

BACKER - MED-1 (Rev. 1/2020)