

# Health Requirements for Students Entering 7th 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.*

## **TDAP and MCV vaccinations are mandatory for 7th grade!**

***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 dental exam is required for 7th 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, 7th Grade
2. Medications in Schools
3. Report of Private Dental Examination (MEH-155)
4. Student Medical Information (S-865)
5. Request for Administration of Medication (MED-1)



# Immunization Requirements

## IS YOUR CHILD READY FOR 7TH GRADE?



### DID YOU KNOW...

...the Pennsylvania Department of Health requires all children entering 7th grade submit the required proof of vaccinations prior to school attendance or they will not be able to attend school? It's the law.

Follow these steps to make sure your child is ready for school.



### SCHEDULE

bring your child a well visit to ensure they receive the required 7th grade vaccinations:

- Tdap (tetanus, diphtheria, pertussis)—1 dose
- Meningococcal Conjugate (MCV4)—1 dose



### OBTAIN

a medical certificate signed by your child's doctor, detailing the plan to complete vaccines **if the next dose is not medically appropriate.**

You can get the form at [philasd.org/VAX](http://philasd.org/VAX).



### SUBMIT

documentation **if your child is exempt from any immunization(s)** for a medical, religious or philosophical/strong moral reason. If your child is exempt he or she may be removed from school during an outbreak.

You can get the form at [philasd.org/VAX](http://philasd.org/VAX).

Call your child's doctor or a city health center today!

To schedule an appointment at a health center call (215) 685-2933.



*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

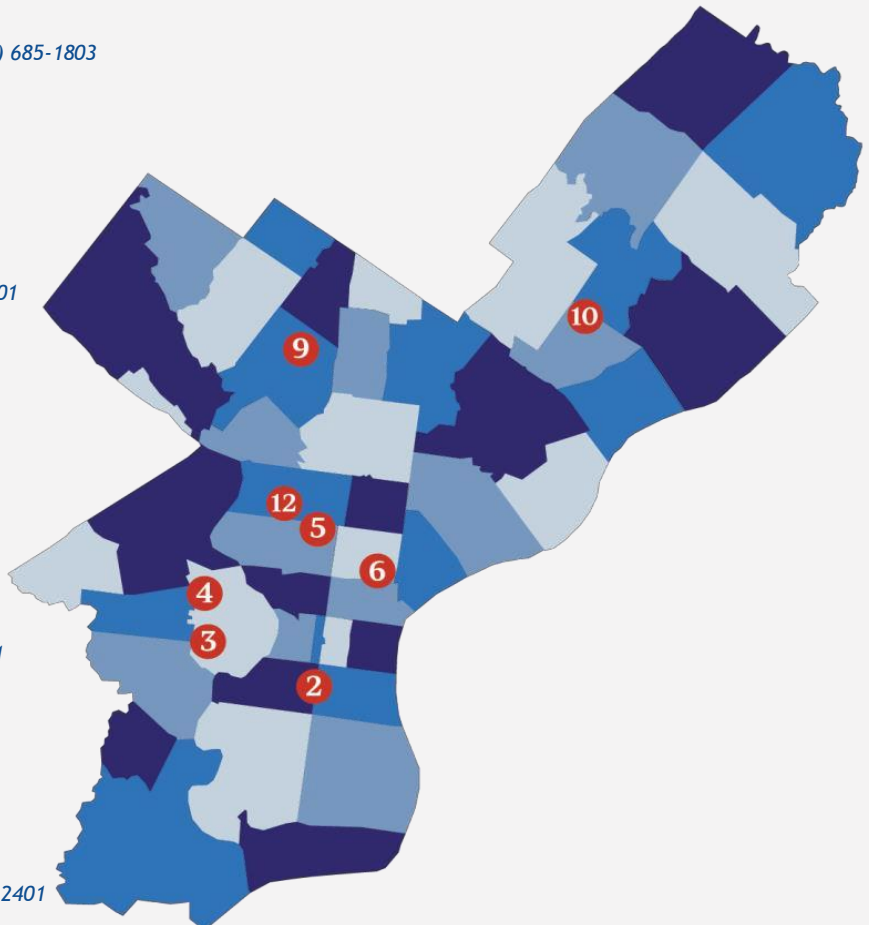
131 E. Cheltenham Ave., Philadelphia, PA 19144 (215) 685-5701

### 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



# 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**  
**REPORT OF PRIVATE DENTAL EXAMINATION**

Name of School <b>St. Barnabas School</b>	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	<input type="checkbox"/> No Treatment Required Now
Scheduled Follow-up Appointment	<input type="checkbox"/> 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:**

Michael Corbit, CSN

Certified School Nurse/Practitioner

St. Barnabas School

School

6334 Buist Avenue Philadelphia, PA 19142

School Address

215-729-3603    fax: 215-689-4346

Phone Number







# 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 \_\_\_\_\_

<p><b>Please circle below to give permission to the school nurse to give your child medication.</b></p> <table border="1"> <tr> <td>Acetaminophen(Tylenol)</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Ibuprofen (Motrin)</td> <td>Yes</td> <td>No</td> </tr> </table>	Acetaminophen(Tylenol)	Yes	No	Ibuprofen (Motrin)	Yes	No	<p>Please <b>CIRCLE</b> the following if your child:</p> <p>Wears: Glasses      Hearing aid          Has: Seizures    Diabetes    Asthma    ADHD</p> <p><b>List Allergies:</b> _____  <small>and substitution requires a new order yearly from a health care provider:</small> _____</p> <p><b>Other Health Problems:</b> _____          _____          _____</p>
Acetaminophen(Tylenol)	Yes	No					
Ibuprofen (Motrin)	Yes	No					

**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 \_\_\_\_\_



# 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.
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DATE OF BIRTH	SCHOOL/ORG.# St. Barnabas School	REGIONAL OFFICE	PID
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DIAGNOSIS: \_\_\_\_\_

REASON MEDICATION MUST BE GIVEN IN SCHOOL: \_\_\_\_\_

NAME OF MEDICATION/EQUIPMENT/TREATMENT:	DOSE:
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TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:
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DATE BEGIN:	DATE END:
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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
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ADDRESS	EMERGENCY NUMBER
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SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED
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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 \_\_\_\_\_

**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

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**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)